FLEXPLAN

The benefits of choice

The HSHS Healthy Plan

Eastern Wisconsin Division

Health insurance coverage for you, your spouse, and/or your dependent children.

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HEALTHY PLAN OPTIONS

The benefits outlined in this Summary Plan Description apply to HSHS Colleagues and individuals with coverage under the Plan's Continuation of Coverage provisions whose primary home residence is in Eastern Wisconsin, as defined by the zip codes listed in Appendices A and B and their dependents. For the health benefits that apply to HSHS Colleagues and individuals with coverage under the Plan's Continuation of Coverage provisions who do not reside in Eastern Wisconsin and their dependents, please see the HSHS Healthy Plan SPD.

The amount of benefits you receive from the HSHS Healthy Plan depends on the option you choose when you enroll. The Plan offers three Exclusive Provider Organization (EPO) medical options:

- Basic Option
- Intermediate Option
- High Option

The deductibles, co-insurance and out-of-pocket limits that apply to each option are shown in the ***Summary Schedule of Benefits*** that follows this section.

Dean Health Plan Administrative Services (DHP) administers the HSHS Healthy Plan for HSHS Eastern Wisconsin colleagues.

Navitus Health Solutions administers the Prescription Drug benefits of the HSHS Healthy Plan for HSHS Eastern Wisconsin colleagues.

This Plan is intended, designed and administered as a "church plan" as defined by federal tax law and ERISA (Employee Retirement Income Security Act of 1974). This means that the plan is designed to benefit colleagues of church-sponsored entities, and is administered by one or more individuals who are appointed to their position by a church-sponsored governance body. Because the plan is a "church plan", certain federal laws do not apply, including but not limited to ERISA.

SUMMARY SCHEDULE OF BENEFITS

The Plan pays the percentages shown. The Member pays any Copay before the applicable percentage is applied. These do not reflect any services not covered by the Plan, benefit reductions caused by not complying with Prior Authorization or out-of-network charges for which you are also responsible.

*See the **Covered Services** section for limitations that apply to some Treatments; **Utilization Management Services** for the Prior Authorization requirements that apply to some services.*

Basic Option	**Network Facility**	**Network Primary Care Physician**	**Network Specialist Physician**	**Out of Network** **Facility or Professional**
Wellness and Preventive Care	100% of eligible charges, no deductible			No coverage
Annual Medical Deductible	*all cross apply*			
Per Individual	None	None	$1,750	No Coverage
Family Limit	None	None	$3,500	No Coverage
Annual Medical Out-of-Pocket Maximum	*includes the Medical Deductible*			
Per Individual	$3,600			No Coverage
Family Limit	$7,200			No Coverage
Physician Charges				
Office Visit Charge/ Allergy Serums/Injections	N/A	95%	75%	No Coverage
Spinal Manipulations (up to 10 per calendar year)	N/A	95%*	75%*	No Coverage
Surgery/Procedure/All Other (all settings)	N/A	95%	75%*	No Coverage
Outpatient Imaging and Lab (all settings)				
Advanced Imaging[1]	75%	75%	75%	No Coverage
Other Imaging & Lab (includes allergy testing)	75%	75%	75%	No Coverage
Hospital/Facility Charges IP/OP	75%	N/A	N/A	No Coverage
Emergency Room Care				
Medical Emergency/Emergency Accident	$100 Copay then 75%	95%	75%*	Same as Network[3]
Other Conditions	$100 Copay then 75%	95%	75%*	No Coverage
Ambulance	75%	95%	75%	Same as Network[3]
Urgent Care Center	75%	95%	75%*	No Coverage[4]
Private Duty Nursing	75%	N/A	N/A	No Coverage
Home Health Services and Hospice	75%	95%	75%	No Coverage
Mental Health & Substance Abuse				
Office Visits	N/A	95%	75%	No Coverage
Other Outpatient and Inpatient	75%	95%	75%	No Coverage
Outpatient Therapy Services[2] /Cardiac Rehab / Dialysis / DME	75%	95%	75%	No Coverage
Other Covered Services	75%	95%	75%	No Coverage

* after annual Medical Deductible is met

[1] Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. Prior approval required.

[2] Therapy Services include physical, occupational and speech therapy , radiation therapy, chemotherapy and electroconvulsive therapy.

[3]Same as Network means the applicable Network medical Deductible, Coinsurance percentage and Out-of-Pocket Maximum apply.

[4]Urgent Care services while traveling outside your Network service area are covered. Plan payments to Out-of-Network Providers are based on the Eligible Charge. If an Out-of-Network Provider bills more than the Eligible Charge, you are responsible for the additional amount.

Prescription Drugs	**Retail Network Pharmacy (up to 30 day supply per Rx)**	**WellDyneRx Mail Order (up to 90 day supply per Rx)**
Annual Prescription Drug Deductible	$400 per Covered Person per Plan Year	
Annual Prescription Drug Out-of-Pocket Maximum	$1,600 per Covered Person per Plan Year; $3,200 Family Limit	
Preferred Generic Prescription Drugs	80%*	80%*
Preferred Brand Name Prescription Drugs	70%*	70%*
Non-Preferred Prescription Drugs	Deductible, $15 Copay per Rx then 70%	Deductible, $45 Copay per Rx then 70%

* after annual Prescription Drug Deductible is met

If you choose to receive a brand name medication when a direct generic equivalent is available, you are responsible for paying the difference in price between the brand drug and its generic equivalent in addition to the Plan's Prescription Drug Deductible and Coinsurance. This Ancillary Fee does not apply to the Prescription Drug Deductible or Prescription Drug Out-of-Pocket Maximum.

The Plan pays the percentages shown. The Member pays any Copay before the applicable percentage is applied. These do not reflect any services not covered by the Plan, benefit reductions caused by not complying with Prior Authorization or out-of-network charges for which you are also responsible.

See the ***Covered Services*** *section for limitations that apply to some Treatments;* ***Utilization Management Services*** *for the Prior Authorization requirements that apply to some services.*

Intermediate Option	**Network Facility**	**Network Primary Care Physician**	**Network Specialist Physician**	**Out of Network**
				Facility or Professional
Wellness and Preventive Care	100% of eligible charges, no deductible			No coverage
Annual Medical Deductible	*all cross apply*			
Per Individual	None	None	$1,200	No Coverage
Family Limit	None	None	$2,400	No Coverage
Annual Medical Out-of-Pocket Maximum	*Includes the Medical Deductible*			
Per Individual	$3,100			No Coverage
Family Limit	$6,200			No Coverage
Physician Charges				
Office Visit Charge/ Allergy Serums/Injections	N/A	95%	80%	No Coverage
Spinal Manipulations (up to 10 per calendar year)	N/A	95%*	80%*	No Coverage
Surgery/Procedure/All Other (all settings)	N/A	95%	80%*	No Coverage
Outpatient Imaging and Lab (all settings)				
Advanced Imaging[1]	80%	80%	80%	No Coverage
Other Imaging & Lab (includes allergy testing)	80%	80%	80%	No Coverage
Hospital/Facility Charges IP/OP	80%	N/A	N/A	No Coverage
Emergency Room Care				
Medical Emergency/Emergency Accident	$100 Copay then 80%	95%	80%*	Same as Network[3]
Other Conditions	$100 Copay then 80%	95%	80%*	No Coverage
Ambulance	80%	95%	80%	Same as Network[3]
Urgent Care Center	80%	95%	80%*	No Coverage[4]
Private Duty Nursing	80%	N/A	N/A	No Coverage
Home Health Services and Hospice	80%	95%	80%	No Coverage
Mental Health & Substance Abuse				
Office Visits	N/A	95%	80%	No Coverage
Other Outpatient and Inpatient	80%	95%	80%	No Coverage
Outpatient Therapy Services[2] /Cardiac Rehab / Dialysis / DME	80%	95%	80%	No Coverage
Other Covered Services	80%	95%	80%	No Coverage

* after annual Medical Deductible is met

[1] *Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. Prior approval required.*

[2] *Therapy Services include physical, occupational and speech therapy, radiation therapy, chemotherapy and electroconvulsive therapy.*

[3] *Same as Network means the applicable Network medical Deductible, Coinsurance percentage and Out-of-Pocket Maximum apply.*

[4] *Urgent Care services while traveling outside your Network service area are covered. Plan payments to Out-of-Network Providers are based on the Eligible Charge. If an Out-of-Network Provider bills more than the Eligible Charge, you are responsible for the additional amount.*

Prescription Drugs	**Retail Network Pharmacy (up to 30 day supply per Rx)**	**WellDyneRx Mail Order (up to 90 day supply per Rx)**
Annual Prescription Drug Deductible	$300 per Covered Person per Plan Year	
Annual Prescription Drug Out-of-Pocket Maximum	$1,600 per Covered Person per Plan Year; $3,200 Family Limit	
Preferred Generic Prescription Drugs	80%*	80%*
Preferred Brand Name Prescription Drugs	70%*	70%*
Non-Preferred Prescription Drugs	Deductible, $15 Copay per Rx then 70%	Deductible, $45 Copay per Rx then 70%

* after annual Prescription Drug Deductible is met

If you choose to receive a brand name medication when a direct generic equivalent is available, you are responsible for paying the difference in price between the brand drug and its generic equivalent in addition to the Plan's Prescription Drug Deductible and Coinsurance. This Ancillary Fee does not apply to the Prescription Drug Deductible or Prescription Drug Out-of-Pocket Maximum.

The Plan pays the percentages shown. The Member pays any Copay before the applicable percentage is applied. These do not reflect any services not covered by the Plan, benefit reductions caused by not complying with Prior Authorization or out-of-network charges for which you are also responsible.

*See the **Covered Services** section for limitations that apply to some Treatments; **Utilization Management Services** for the Prior Authorization requirements that apply to some services.*

High Option	**Network Facility**	**Network Primary Care Physician**	**Network Specialist Physician**	**Out of Network**
				Facility or Professional
Wellness and Preventive Care	100% of eligible charges, no deductible			No coverage
Annual Medical Deductible	*all cross apply*			
Per Individual	None	None	$800	No Coverage
Family Limit	None	None	$1,600	No Coverage
Annual Medical Out-of-Pocket Maximum	*Includes the Medical Deductible*			
Per Individual	$2,750			No Coverage
Family Limit	$5,500			No Coverage
Physician Charges				
Office Visit Charge/ Allergy Serums/Injections	N/A	95%	80%	No Coverage
Spinal Manipulations (up to 10 per calendar year)	N/A	95%*	80%*	No Coverage
Surgery/Procedure/All Other (all settings)	N/A	95%	80%*	No Coverage
Outpatient Imaging and Lab (all settings)				
Advanced Imaging[1]	90%	90%	90%	No Coverage
Other Imaging & Lab (includes allergy testing)	90%	90%	90%	No Coverage
Hospital/Facility Charges IP/OP	90%	N/A	N/A	No Coverage
Emergency Room Care				
Medical Emergency/Emergency Accident	$100 Copay then 90%	95%	80%*	Same as Network[3]
Other Conditions	$100 Copay then 90%	95%	80%*	No Coverage
Ambulance	90%	95%	90%	Same as Network[3]
Urgent Care Center	90%	95%	90%*	No Coverage[4]
Private Duty Nursing	90%	N/A	N/A	No Coverage
Home Health Services and Hospice	90%	95%	90%	No Coverage
Mental Health & Substance Abuse				
Office Visits	N/A	95%	80%	No Coverage
Other Outpatient and Inpatient	90%	95%	90%	No Coverage
Outpatient Therapy Services[2] /Cardiac Rehab / Dialysis / DME	90%	95%	90%	No Coverage
Other Covered Services	90%	95%	90%	No Coverage
Lifetime Benefit Maximum	Unlimited			

* after annual Medical Deductible is met

[1] Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. Prior approval required.

[2] Therapy Services include physical, occupational and speech therapy, radiation therapy, chemotherapy and electroconvulsive therapy.

[3] Same as Network means the applicable Network medical Deductible, Coinsurance percentage and Out-of-Pocket maximum apply.

[4] Urgent Care services while traveling outside your Network service area are covered. Plan payments to Out-of-Network Providers are based on the Eligible Charge. If an Out-of-Network Provider bills more than the Eligible Charge, you are responsible for the additional amount.

Prescription Drugs	**Retail Network Pharmacy (up to 30 day supply per Rx)**	**WellDyneRx Mail Order (up to 90 day supply per Rx)**
Prescription Drug Deductible	$150 per Covered Person per Plan Year	
Prescription Drug Out-of-Pocket Maximum	$1,300 per Covered Person per Plan Year; $2,600 Family Limit	
Preferred Generic Prescription Drugs	80%*	80%*
Preferred Brand Name Prescription Drugs	70%*	70%*
Non-Preferred Prescription Drugs	Deductible, $15 Copay per Rx then 70%	Deductible, $45 Copay per Rx then 70%

* after annual Prescription Drug Deductible is met

If you choose to receive a brand name medication when a direct generic equivalent is available, you are responsible for paying the difference in price between the brand drug and its generic equivalent in addition to the Plan's Prescription Drug Deductible and Coinsurance. This Ancillary Fee does not apply to the Prescription Drug Deductible or Prescription Drug Out-of-Pocket Maximum.

COMMON FEATURES - ALL OPTIONS

WELLNESS AND PREVENTIVE CARE

When provided by a Network Provider, the Plan pays 100% of Eligible Charges with no deductible for the following preventive/routine services for all three options:

- Periodic recommended well-child and health education/counseling, Preventive physical exams are covered according to the following schedule:
  - 7 exams in the first 12 months of life
  - 3 exams in the second 12 months of life
  - 3 exams in the third 12 months of life
  - 1 exam per year after age 3
- Annual adult examinations, screenings, and health education/counseling
- Routine immunizations and inoculations for infectious disease in accordance with the Centers for Disease Control and Prevention's and Advisory Committee for Immunization Practice's recommendations.
  - For adults, these include:
    - ú Hepatitis A
    - ú Hepatitis B
    - ú Human Papillomavirus (HPV) for individuals age 9 to 26 years old
    - ú Influenza
    - ú MMR (measles, mumps, rubella)
    - ú Meningococcal
    - ú Pneumococcal vaccine
    - ú Tetanus, diphtheria, pertussis (Td/Tdap)
    - ú Tuberculosis (TN)
    - ú Haemophilus influenza (Hib)
    - ú Varicella (chickenpox)
    - ú Zoster (shingles) for individuals age 60 or older
  - For children, these include:
    - ú Diphtheria, tetanus, pertussis (DTaP or Tdap)
    - ú Haemophilus influenza type b (Hib)
    - ú Hepatitis A
    - ú Hepatitis B
    - ú Human Papillomavirus (HPV)
    - ú Inactivated poliovirus
    - ú Influenza
    - ú MMR (measles, mumps, rubella)
    - ú Meningococcal
    - ú Pneumococcal vaccine
    - ú Rotavirus
    - ú Varicella (chickenpox)
    - ú Gonorrhea for newborns

- The Plan provides coverage for the following Routine immunizations and inoculations at a Network Pharmacy:
  - Hepatitis A and B
  - Human Papillomavirus (HPV)
  - Influenza
  - MMR (measles, mumps, rubella)
  - Meningococcal
  - Pneumococcal vaccine (PPSV)
  - Tetanus, diphtheria, pertussis (Td/Tdsp)
  - Varicella (chickenpox
  - Zoster (shingles)
- Gynecological examination, including pelvic and clinical breast exam, genetic counseling and evaluation for BRCA testing, cervical cancer screening including Pap smear, ovarian cancer screening, and urinalysis
- Digital rectal exam (DRE) (prostate exam)
- Routine hearing screening
- One annual depression screening
- Screening mammography for women (including digital breast tomosynthesis – 3D mammograms)
- Abdominal aortic aneurysm one-time screening for men between the ages of 65 and 75
- Colonoscopy, sigmoidoscopy, or double-contrast barium enema (both facility and Physician charges) including preparatory medications subject to reasonable medical management
- Bone density screening, for individuals at risk of osteoporosis for individuals over age 60
- The following diagnostic lab tests when ordered at the time of a covered preventive care visit: total cholesterol and HDL screening, Pap smear, blood glucose, complete blood count (CBC), high risk Human Papillomavirus (HPV) testing for women between the ages of 30 and 65, thyroid, prostate specific antigen (PSA) for men, HIV screening, screening for sexually transmitted infections, and fecal occult blood tests
- Routine Diagnostic Services performed in conjunction with an annual physical exam. (Diagnostic Services billed with a diagnosis are not covered under the Plan's ***Wellness and Preventive Care*** provisions. Instead, see the Plan's standard provisions for Diagnostic Services.)
- Diabetes education sessions for individuals diagnosed with diabetes
- Screening tests for children include: hearing, vision, oral health, Hematocrit or hemoglobin, obesity, lead, dyslipidemia (when higher risk of lipid disorder), tuberculin, depression, sexually transmitted infections, HIV, and cervical dysplasia. Additionally, for newborns: hypothyroidism, sickle cell disease, and phenylketonuria (PKU)
- Developmental testing exam for children up to 36 months of age
- Screening tests for pregnant women include: anemia, bacteriuria, Rh incompatibility, gestational diabetes, and Hepatitis B
- Breastfeeding support and counseling by a trained Provider
- Breast pumps, as follows:
  - Manual breast pumps, including those obtained from an out-of-network provider
  - One Electric breast pump per birth

- Hospital grade breast pumps, rental only for up to 12 months or $1,000 whichever comes first (network providers only)

- Breast pump supplies (tubing for breast pump, adapter for breast pump (replacement), cap for breast pump bottle (replacement), breast shield and splash protector for use with breast pump (replacement), polycarbonate bottle for use with breast pump (replacement) and locking ring for breast pump (replacement))
- Tobacco use interventions including screening for tobacco use and two tobacco cessation attempts per year. Cessation attempt includes coverage of:
  - up to four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization and
  - all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization
- Screening and counseling services for:
  - interpersonal and domestic violence,
  - sexually transmitted diseases (counseling limited to twice per year), and
  - HIV infections
- Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance
- Lung cancer screening for adults ages 55-80 with a history of smoking
- Screening and counseling services to aid in weight reduction due to obesity
- Generic breast cancer risk reducing medications for women with no prior diagnosis of breast cancer. Coverage for brand name medications at 100% will be provided if the patient's physician determines the generic would not be medically appropriate for the member and submits a request for special review. Coverage of brand products will require Prior Authorization review.

The above list of covered preventive care services may change as United States Preventive Services Task Force ("USPSTF"), Centers for Disease Control and Prevention ("CDC") and Health Resources and Services Administration ("HRSA") guidelines are modified. For more information, you may contact customer service at the toll- free number on your identification card.

Physical exams and related tests and reports solely for the purpose of obtaining or maintaining employment, insurance, governmental licensure, attending camp, participating in sports, admission to school and for premarital purposes are not covered. Vaccinations and inoculations required solely for travel or recreational purposes are not covered.

The HSHS Healthy Plan covers contraceptives only when Medically Necessary.

HEALTHY PARTNER

The Healthy Partner program provides support for Members who visit the emergency room often and those with chronic conditions like diabetes and congestive heart failure. Those who are eligible for this program will be contacted by a care manager who will be available for telephone consultations and in-office visits at two locations – St. Mary's in Decatur, Illinois and St. Vincent in Green Bay, Wisconsin. Participation in the program is voluntary and the program is strictly confidential; no identifying personal health information will be shared with the Employer. The program's care managers will assist Members following a hospital stay or emergency room visit with education on their health condition, scheduling and preparing for doctor

appointments, reviewing and managing medication needs and keeping a check on symptoms and their health condition.

MEDICAL DEDUCTIBLE

You must pay a Medical Deductible each Benefit Period before the Plan pays benefits for certain Covered Services. The deductible applies to each Covered Person and varies based on the option you choose when you enroll and whether you receive services from a Network Facility, Network Primary Care Physician (PCP), or a Network Specialist Physician.

- No deductible applies to Network Facility or Network PCP Covered Expenses.
- If the Covered Expenses applied to the Medical Deductibles for covered Members of your family reach the Medical Deductible Family Limit in a Benefit Period, no additional Medical Deductible will be required for any covered family Member for the rest of that Benefit Period for the Provider category(ies) for which the Medical Deductible Family Limit has been met.
- A separate annual deductible applies to Prescription Drugs.

MEDICAL OUT-OF-POCKET MAXIMUM

To help protect you from the high costs of a very serious illness or Injury, the Plan has a special feature called Medical Out-of-Pocket Maximum.

The Medical Out-of-Pocket Maximum limits the amount of Covered Expenses you have to pay in a Benefit Period. If your share of medical Covered Expenses (the annual Medical Deductible and percentage of medical Covered Expenses not paid by the Plan) for one person reaches the Medical Out-of-Pocket Maximum amount in a Benefit Period, the Plan will pay 100% of any additional medical Covered Expenses incurred by that person for the rest of the Benefit Period.

If the medical out-of-pocket expenses for all your covered family Members combined reach the Medical Out-of-Pocket Maximum Family Limit in a Benefit Period, the Plan will pay 100% of any additional medical Covered Expenses for any covered family Member for the rest of that Benefit Period.

The individual and family Medical Out-of-Pocket Maximums depend on the option you choose when you enroll, as shown in the ***Summary Schedule of Benefits***.

The Medical Out-of-Pocket Maximum does not apply to the following:

- Reductions in benefits caused by not complying with the Plan's Utilization Management requirements.
- Charges that exceed Eligible Charges.
- Charges for services not covered by the Plan.
- Any Prescription Drug expenses. A separate out-of-pocket maximum applies to Prescription Drugs.

NETWORK PROVIDERS

Only Covered Services received from Network Providers, in most cases, will be covered by the Plan options in this SPD.

If you use Network Providers, Eligible Charges will be based on the contract agreement between DHP and the Network Provider. If there is a difference between the contracted amount and the amount that the Provider bills for a Covered Service, you will not be responsible for that amount

OUT-OF-NETWORK PROVIDERS

In most cases, care received from Out-of-Network Providers will not be covered by the Plan options in this SPD. If you receive care from an Out-of-Network Provider without prior approval from the Claim

Administrator, the care will not be covered, unless it is a Medical Emergency, Emergency Accident, or an urgent care service while you are traveling outside of your Network service area. Plan payments for emergency services provided by an Out-of-Network Provider will be based on the Eligible Charge. If there is a difference between the amount the Plan pays and the amount the provider bills, you will be responsible for that amount.

SPECIAL CIRCUMSTANCES

If you need care for which a Network Provider is not available, the services provided by an Out-of-Network Provider will be covered in certain situations. Your Network Provider that is recommending the service must submit a Prior Authorization form to DHP Medical Management. The form must be submitted at least 15 business days prior to the anticipated date of your service. DHP Medical Management will notify you in writing of the decision regarding covering the service provided by an Out-of-Network Provider at the Network Provider level. If you fail to obtain Prior Authorization for any service provided by an Out-of-Network Provider, the service will not be covered, unless it is a Medical Emergency, Emergency Accident, or an urgent care service while you are traveling outside of your Network service area.

DEPENDENTS RESIDING OUTSIDE OF THE NETWORK SERVICE AREA

If a Covered Dependent lives outside out of the Eastern Wisconsin Network Service Area, non-Medical Emergency services that would otherwise be covered by the Plan will be covered by the Plan if received from a Provider in the Multiplan network. These services will be covered at the Network benefit level.

To find a MultiPlan Network provider, call Customer Service at 800-279-9776 or you can search on-line by following these steps:

1. Go to deancare.com/aso
2. Under "Find a Doctor," click "Please Select Your Insurance Network"
3. Select "MultiPlan; MultiPlan PPO"
4. Click on Search for a Doctor or Facility
5. You will be transferred to the MultiPlan site. On that site, select Search for a Doctor or Facility
6. Under Back of Card, check MultiPlan and press Continue.

If there are no Multiplan Providers within 65 miles from the Dependent's address, Covered Services from any Provider will be covered by the Plan at the Network benefit level. Prior Authorization from DHP is required in order for the service to be considered for reimbursement under the terms of the Plan.

Either you or your covered dependent must notify DHP customer service that the Dependent lives outside of the Network Service Area prior to receipt of Services from a MultiPlan Provider or Out-of-Network Provider for the services to be covered by the Plan. This can be done by calling Customer Service at 888-895-1188.

PRESCRIPTION DRUGS

Separate Deductible and Out-of-Pocket Maximum - A separate deductible and maximum out-of-pocket applies to Prescription Drugs. These apply to each Covered Person and are not combined in any way with the Medical Deductibles and Medical Out-of-Pocket Maximums.

If the Prescription Drug out-of-pocket expenses for all your covered family Members combined reach the Prescription Drug Out-of-Pocket Maximum Family Limit in a Benefit Period, the Plan will pay 100% of any additional Prescription Drug Covered Expenses for any covered family Member for the rest of that Benefit Period, exclusive of any Ancillary Fees.

No Coordination - The HSHS Healthy Plan Prescription Drug benefit does not coordinate with other prescription drug plans.

Network Pharmacy Use Required for Benefits - Prescriptions must be obtained from a Navitus Health Solutions Network retail or home delivery pharmacy to be covered.

30 Day Supply at Retail/90 Day Through Mail - Up to a 30-day supply per prescription of a covered Prescription Drug is covered at a retail Network Pharmacy. Up to a 90-day supply per prescription of a covered Prescription Drug is covered through Navitus Health Solutions home delivery pharmacy (WellDyneRx). St. Clare Memorial Hospital covered members may also obtain a 90-day supply per prescription of a covered Prescription Drug through the St. Clare Memorial Hospital Pharmacy.

Ancillary Fee for Certain Brand Name Medications - If you receive a brand name drug when a direct equivalent is available, you are responsible for paying the Ancillary Fee, difference in price between the brand drug and its generic equivalent, in addition to the Plan's Prescription Drug Deductible and Coinsurance. You will be responsible for the Ancillary Fee, even if your physician writes "dispense as written" (DAW1) on your prescription or you have met the Plan's Prescription Drug Deductible or Out-of-Pocket Maximum. Ancillary Fees do not apply to the Plan's Prescription Drug Deductible or Out-of-Pocket Maximum.

Preferred Benefit Difference - For medications that are not Preferred Drugs on the Navitus Health Solutions drug list, the additional $15 retail pharmacy co-pay and $45 mail order co-pay per prescription for Non-Preferred Drugs does not count toward your annual Prescription Drug Deductible or Prescription Drug Out-of-Pocket Maximum.

To see if your medication is a preferred medication, go to www.navitus.com or call 1-866-333-2757.

Formulary Benefit Difference – **A formulary is a list of approved drugs for which the HSHS Healthy Plan provides benefits. The formulary includes Preferred and Non-Preferred Drugs. In order to receive Prescription Drug benefits through this Plan, your medication must be either a Preferred or Non-Preferred Drug on the formulary. The Plan provides enhanced benefits for Preferred Drugs.**

Mail Service Required for Maintenance Drug Benefits - In order to receive Prescription Drug benefits through the HSHS Healthy Plan, you will be required to use Navitus Health Solutions mail service, WellDyneRx, after having a maintenance medication filled two times at a retail pharmacy. If you are a St. Clare Memorial Hospital covered member, you must use either Navitus Health Solutions mail service, WellDyneRx, or the St. Clare Memorial Hospital Pharmacy after having a maintenance medication filled two times at a retail pharmacy.

To see if your medication is a maintenance medication, go to www.navitus.com or call 866-333-2757.

Specialty Pharmacy Required for Specialty Drug Benefits - If you take any self-administered oral or injectable specialty medications, you must purchase these medications through Lumicera, Navitus Health Solutions specialty pharmacy vendor, for the medication to be covered by the HSHS Healthy Plan. If you are a St. Clare Memorial Hospital covered member, you must purchase these medications through either Lumicera or St. Clare Memorial Hospital Pharmacy. Specialty medications include those used to treat multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia and self-administered oral cancer medications. The Plan will cover your initial prescription for a covered medication at a retail pharmacy. After that, you must use Lumicera to have subsequent refills covered. St. Clare Memorial Hospital covered members may also use St. Clare Memorial Hospital Pharmacy.

Prior Authorization, Quantity Limitations, and Step Therapy - Some medications require Prior Authorization by Navitus Health Solutions in order to be covered. Some medications are subject to quantity limitations. Step therapy applies to some medications – before these medications are covered by

the Plan, you may need to first try a proven, cost-effective medication. If your doctor determines that a first-line drug is not appropriate or effective for you, the Plan will cover a second-line drug when certain conditions are met. The medications to which these provisions apply are subject to change. To find out the medications to which these provisions apply, go to www.navitus.com or call 1-866-333-2757.

ELIGIBLE CHARGE LIMITS

When applicable, benefit payments for services provided by Out-of-Network Providers are not based upon the amount billed. For these providers, the Plan covers only that part of a charge for a service or supply that DHP Administrative Services considers an Eligible Charge.

Generally speaking, for Out-of-Network Providers, the Eligible Charge will be the lesser of:

(i) the Provider's billed charge, or;

(ii) the amount determined by the Claim Administrator - approximately 100% of the base Medicare reimbursement rate, excluding any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined by the Claim information, the Eligible Charge for Out-of-Network Professional Providers will be 50% of the Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Out-of-Network Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

NECESSARY MEDICAL CARE

You can receive benefits only for charges incurred by a Covered Person for the services and supplies listed in the section titled ***Covered Services***. These services and supplies must be prescribed by or ordered by a Physician, or other medical professional acting within the scope of his or her license, for the Medically Necessary Treatment of a non-occupational illness or Injury, or for covered ***Wellness and Preventive Care***, and provided according to generally accepted medical practice.

Any expense for which a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person was not covered under the Plan are not covered by the Plan. Expenses for services or supplies for which a Health Care Provider specifically limits its charges to only those paid by this Plan are not covered by the Plan.

Please review the ***Utilization Management*** section for the Prior Authorization requirements that apply to some services in order to receive full benefits under the Plan.

DEFINITIONS

When the following terms are used in this booklet, these definitions apply:

Activities of Daily Living: Include, but are not limited to:

Ambulation	Eating	Shopping
Bathing	Grasping	Sitting
Bowel And Bladder Control	Judgment/Cognitive Function	Standing
Cleaning	Laundry	Taking Medications
Climbing Stairs	Lifting	Toileting
Communications	Managing Money	Transfer From Bed
Cooking	Pushing/Pulling	Transfer From Toilet
Dressing	Reaching	Using A Telephone
Driving A Motor Vehicle	Reading	Using Public Transportation
		Writing

Active Employment: You must be working for your Employer. Normal vacation and holidays are considered Active Employment. An absence for any other reason is not considered Active Employment.

Advanced Imaging: PET scans, CAT scans, MRIs, MRAs, bone density testing and sleep studies.

Advanced Practice Nurse: a Certified Clinical Nurse Specialist, Certified Nurse–Midwife, Certified Nurse Practitioner or Certified Registered Nurse Anesthetist.

Affiliate: one of the employers listed in the Eligibility section of this document.

Ancillary Fee: the difference in price between a brand name drug and its generic equivalent.

Ambulatory Surgical Facility: a facility (other than a Hospital) whose primary function is the provision of surgical procedures on an ambulatory basis and which is duly licensed by the appropriate state and local authority to provide such services.

Applied Behavioral Analysis (ABA): an early intensive behavioral intervention that encompasses behavior modification training programs that are based on the theory that behavior is learned through interaction between an individual and the environment. The goal of the behavior management is to reinforce and increase desirable, functional behaviors while reducing undesirable, "maladaptive" behaviors.

Autism Spectrum Disorders: A broad range of developmental disorders, which includes autism, Asperger's syndrome, pervasive development disorder, Rhett's disorder, and childhood disintegrative disorder (CDD). For an Autism Spectrum Disorder diagnosis to be valid for purposes of this Plan, the evidence must meet the criteria for Autism Spectrum Disorder in the most recent Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Benefit Period: the Benefit Period is a one year period that begins on January 1st and ends on December 31st each calendar year. When you first enroll in the Plan, your first Benefit Period begins on your Coverage Date and ends on the first December 31st following that date.

Break in Service: A Break in Service occurs when you do not have an Hour of Service for a period of 13 consecutive weeks or longer. The Plan Administrator, at its discretion, may also determine whether you have had a Break in Service using the Rule of Parity.

Benefits Eligible Colleague: If HSHS reasonably expects you to work at least 32 hours or more bi-weekly on a regular basis, HSHS will classify you as a Benefits Eligible Colleague for purposes of coverage under this Plan.

Certified Clinical Nurse Specialist: a nurse specialist who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

Certified Nurse–Midwife: a nurse–midwife who (a) practices according to the standards of the American College of Nurse–Midwives; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of a program of nurse–midwives accredited by the American College of Nurse Midwives or its predecessor.

Certified Nurse Practitioner (or Nurse Practitioner): a nurse practitioner who (a) is licensed under the Nursing and Advanced Practice Nursing Act; (b) has an arrangement or agreement with a Physician for obtaining medical consultation, collaboration and hospital referral and (c) meets the following qualifications:

(i) is a graduate of an approved school of nursing and holds a current license as a registered nurse; and

(ii) is a graduate of an advanced practice nursing program.

Certified Registered Nurse Anesthetist Or CRNA: a nurse anesthetist who: (a) is a graduate of an approved school of nursing and is duly licensed as a registered nurse; (b) is a graduate of an approved program of nurse anesthesia accredited by the Council of Accreditation of Nurse Anesthesia Education Programs/Schools or its predecessors; (c) has been certified by the Council of Certification of Nurse Anesthetists or its predecessors; and (d) is recertified every two years by the Council on Recertification of Nurse Anesthetists.

Chemotherapy: the treatment of malignant conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Claim: notification in a form acceptable to the Claim Administrator that a service has been rendered or furnished to you. This notification must include full details of the service received, including your name, age, sex, identification number, the name and address of the Provider, an itemized statement of the service rendered or furnished, the date of service, the diagnosis, the Claim Charge, and any other information which the Claim Administrator may request in connection with services rendered to you.

Claim Administrator: DHP Administrative Services.

Claim Charge: the amount which appears on a Claim as the Provider's charge for a service rendered to you, without adjustment or reduction and regardless of any separate financial arrangement between the Claim Administrator and a particular Provider.

Claim Form: the form posted on the Claims Administrator's web site to be used to notify the Claim Administrator that a service has been rendered or furnished to you.

Clinical Efficacy: the Treatment satisfies both of the following:

a) it can reasonably be expected to improve survival, health or function to alleviate symptoms of or stabilize that condition; and
b) its use outweighs any potential harm.

Coinsurance: the percentage of a Covered Expense that you are required to pay towards a Covered Service.

Colleague: means a person who is in Active Employment with the Employer (same as employee).

Coordinated Home Care: part-time or intermittent nursing care by, or under the supervision of, a Registered Nurse (R.N.), and associated supplies, furnished in the patient's home.

Copay: a specified dollar amount that you are required to pay towards a Covered Service. In some cases, you must pay both a Copay and Coinsurance or the Prescription Drug Deductible, a Copay and Coinsurance.

Coverage Date: the date on which your coverage under the HSHS Healthy Plan begins.

Covered Expense: the Eligible Charge for a Covered Service. This is the amount used to determine the benefits payable by the Plan.

Covered Person: a Subscriber or Dependent who has satisfied the Plan's eligibility conditions and is enrolled in coverage under the Plan.

Covered Service: a service or supply specified in this SPD for which benefits will be provided. See the ***Covered Services*** section.

Custodial Care: any service primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your condition. Custodial Care also means those services which do not require the technical skills, professional training and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non–professional personnel, to assist with routine medical needs (e.g. simple care and dressings, administration of routine medications, etc.) or Activities of Daily Living. Custodial Care also means care on a continuous Inpatient or Outpatient basis without any clinical improvement by the Covered Person receiving the services.

Dependent: a person of the Subscriber's family who is eligible for coverage under the Plan according to the provisions outlined in the ***Dependent Eligibility*** section.

Dialysis Facility: a facility (other than a Hospital) whose primary function is the treatment and/or provision of maintenance and/or training dialysis on an ambulatory basis for renal dialysis patients and which is duly licensed by the appropriate governmental authority to provide such services.

Diagnostic Service: tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a condition, disease or Injury. Such tests include, but are not limited to, x–rays, pathology services, clinical laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

Durable Medical Equipment: equipment which (a) can withstand repeated use, (b) is primarily and customarily used to serve a medical purpose, (c) generally is not useful to a person in the absence of an Illness or Injury and (d) is appropriate for use in the home.

Eastern Wisconsin Network Service Area: The area defined by the zip codes listed in Appendix A and Appendix B.

Eligible Charge: in the case of a Network Provider is the Maximum Allowable Charge, in the case of an Out-of-Network Provider at the time Covered Services are rendered, will be the lesser of:

(i) the Provider's Claim Charge, or; the Claim Administrator non–contracting Eligible Charge. Except as otherwise provided in this section, the non–contracting Eligible Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Eligible Charge for Out-of-Network Providers will be 50% of the Out-of-Network Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Provider Claims for processing Claims submitted by Out-of-Network Providers which may also alter the Eligible Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Eligible Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Emergency Accident: an accident that results in a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Employer: Hospital Sisters Health System (HSHS) and its Affiliates.

Enrollment Date: the date that an individual is first employed by an Affiliate in a position that meets the requirements specified in the ***Eligibility*** section of this SPD.

Experimental or Investigational: procedures, drugs, devices, services and/or supplies which (1) are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency and effectiveness, and/or (2) are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and (3) specifically with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Extended Care Facility (or Skilled Nursing Facility): an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and which:

1. mainly provides Inpatient care and treatment for persons recovering from an illness or Injury;
2. provides care supervised by a Physician;
3. provides 24 hour per day nursing care supervised by a full-time registered nurse;
4. is not a place primarily for care of the aged, Custodial Care, or treatment of alcohol or drug dependency; and

5. is not a rest, educational, or custodial Provider or similar place.

Flexplan: the HSHS employee benefit program that allows Colleagues to pay for their portion of the cost of Healthy Plan coverage with pre-tax contributions.

Formulary: a list of pharmaceutical products, developed in consultation with Physicians and pharmacists, approved for their quality and cost effectiveness by the Pharmacy Benefit Manager, for which benefits are provided by the Plan.

Generally Accepted by the Medical Community in the United States: the Clinical Efficacy of the Treatment has been documented in credible published medical literature which demonstrates that the results of the treatment have been measured for a 5 year period or other period generally regarded as valid.

Habilitative Services: Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a Treatment plan to enhance the ability of a Member to keep, learn, or improve skills and functioning for daily living for treatment of those conditions that are expected to yield significant patient improvement as determined by the Claim Administrator. Therapists must be licensed and must not live in the patient's home or be a family member.

Health Care Providers or Providers: a duly licensed person or facility that provides services within the scope of an applicable license. Providers include, but are not limited to, the following persons and facilities:

- Physicians, nurse practitioners and physician assistants who practice within the scope of their professional license.
- For treatment of mental health disorders or chemical dependency, this term will include a clinical psychologist with a graduate degree, a social worker with a graduate degree (MSW), a licensed social worker and a certified therapist who is working under the direct supervision of a physician or psychologist.
- For treatment of eye diseases and Injuries, this term will include an optometrist who is working under the direct supervision of a physician.
- Certified Registered Nurse
- Home Health Care Agency
- Hospice
- Hospital
- Licensed occupational therapists, licensed professional physical therapists, physiotherapists, and speech language pathologists.
- Urgent Care Center - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, to treat an unexpected episode of illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care, but is not considered a Medical Emergency.

Provider also means a person acting within the scope of applicable state requirements under the direction of one of the persons listed within this definition or performing services as a part of his/her employment by a facility listed within this definition.

Home Health Care Agency: a public or private agency or organization licensed in the state in which it is located to provide Coordinated Home Care services.

Hour of Service: any hour for which you are paid, or entitled to payment, for (1) the performance of duties for HSHS or (2) for a period of time during which no duties are performed due to vacation,

holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. An Hour of Service does not include:

- Hours for which your compensation is considered non-US source income
- Hours worked as a volunteer
- Hours worked as part of a Federal Work-Study Program

An hour of overtime counts as one hour of service, regardless of the rate you are paid.

Hospice: a coordinated plan of home, Inpatient and Outpatient care which provides palliative and supportive medical and other health services to terminally ill patients. An interdisciplinary team provides a program of planned and continuous care, of which the medical components are under the direction of a Physician. Care will be available 24 hours a day, seven days a week. The Hospice must meet the licensing requirements of the state or locality in which it operates.

Hospital: a lawfully operating institution engaged in providing medical, diagnostic and surgical facilities for the care and treatment of sick or injured persons on an Inpatient basis, which provides such service under the supervision of physicians, with 24-hour service by Registered Nurses, and which provides such service in return for compensation from its patients. This definition includes an institution which provides treatment for mental infirmities or nervous disorders, drug addiction, or alcoholism and which otherwise qualifies as a Hospital except for a lack of surgical facilities. This does not include any institution or any portion of an institution which is used, other than incidentally, as a rest home, nursing home or home for the aged.

HSHS Facility: one of the Hospitals in which Hospital Sisters Health System has 100% ownership or a designated join venture in which HSHS has 50% or greater ownership. In order for services to be paid at the HSHS Facility rate, the service must be billed on a UB form under a HSHS provider I.D. number.

HSHS Health and Welfare Benefits Plan: the HSHS Colleague benefit program of which the HSHS Healthy Plan is a component.

Individual Coverage: coverage under the HSHS Healthy Plan for an eligible Colleague or former colleague but not the Colleague's/retiree's Dependents.

Initial Measurement Period: The period of time beginning on the first of the month following a New Colleague's first day of employment with the Employer and ending 12 months later. Similarly, for a Colleague who returns to work after a Break in Service, the period of time beginning on the first of the month following the Colleague's first day of employment with the Employer following the Break in Service and ending 12 months later.

Initial Stability Period: The period of time beginning on the first day of the month one month after the end of a New Colleague's Initial Measurement Period. (For example, if your Initial Measurement Period is May 1, 2015 – April 30, 2016, your Initial Stability Period is June 1, 2016 through May 31, 2017.)

Injury: any physical trauma to the body, unrelated to employment.

Inpatient: you are a registered bed patient and are treated as such in a health care facility.

Long Term Care Services: those social services, personal care services and/or Custodial Care Services needed by you when you have lost some capacity for self–care because of a chronic illness, Injury or condition.

Lookback Eligibility Method: One of the Plan's methods for determining a Colleague's eligibility to participate in the Plan. See the ***Lookback Eligiblity Method*** sub-section of this SPD's ***Eligibility*** section for further information.

Maintenance Care and Maintenance Therapy: those services administered to you to maintain a level of function at which no demonstrable and/or measurable improvement of condition will occur. Maintenance Therapy means Occupational Therapy, Speech Therapy, or Physical Therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a condition will occur.

Maximum Allowable Charge: (a) the amount that Network Providers have agreed to accept as payment in full for a particular Covered Service. All benefit payments for Covered Services rendered by Network Providers will be based on the schedule that these Providers have agreed to accept as payment in full. (b) For Out-of-Network Professional Providers, the Maximum Allowable Charge will be the lesser of:

(i) the Provider's Claim Charge, or;

(ii) the Claim Administrator non–contracting Maximum Allowable Charge. Except as otherwise provided in this section, the non–contracting Maximum Allowable Charge is developed from base Medicare reimbursements and represents approximately 100% of the base Medicare reimbursement rate and will exclude any Medicare adjustment(s) which is/are based on information on the Claim.

When a Medicare reimbursement rate is not available for a Covered Service or is unable to be determined on the information submitted on the Claim, the Maximum Allowable Charge for Out-of-Network Professional Providers will be 50% of the Out-of-Network Professional Provider's standard billed charge for such Covered Service.

The Claim Administrator will utilize the same Claim processing rules and/or edits that it utilizes in processing Network Professional Provider Claims for processing Claims submitted by Out-of-Network Professional Providers which may also alter the Maximum Allowable Charge for a particular service. In the event the Claim Administrator does not have any Claim edits or rules, the Claim Administrator may utilize the Medicare claim rules or edits that are used by Medicare in processing the Claims. The Maximum Allowable Charge will not include any additional payments that may be permitted under the Medicare laws or regulations which are not directly attributable to a specific Claim, including, but not limited to, disproportionate share payments and graduate medical education payments.

Any change to the Medicare reimbursement amount will be implemented by the Claim Administrator within 145 days after the effective date that such change is implemented by the Centers for Medicaid and Medicare Services, or its successor.

Measurement Period: The period of time during which a Colleague's Hours of Service are measured to determine eligibility for this Plan under the ***Lookback Eligibility Method***. For additional Information see Initial Measurement Period and Standard Measurement Period.

Medical Deductible: the dollar amount of Covered Expenses listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period before benefits are payable under the Plan for Covered Services for medical care.

Medical Deductible Family Limit: the maximum dollar amount of Medical Deductibles listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period for all covered Members of your family.

Medical Emergency: sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences. Examples of medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

Medical Necessity or Medically Necessary: The Treatment, services, or supplies provided by a Hospital or Provider that are required to identify or treat a Member's illness or Injury and which, as determined by the Claims Administrator, are: (a) consistent with the Member's illness or Injury; (b) in accordance with generally accepted standards of medical practice; (c) not solely for the convenience of a Member, Hospital, or other Provider; and (d) the most appropriate supply or level of service that can be safely provided to the Member in the most cost effective manner. Psychological reactions to appearance or fear of disease do not constitute a basis for Medical Necessity, other than for Mental Illness.

The fact that a Physician has performed or prescribed a procedure or Treatment or the fact that it may be the only Treatment for a particular illness or Injury does not mean that it is Medically Necessary. The definition used to determine Medical Necessity by the Plan may differ from the way a Physician engaged in the practice of medicine defines medically necessary.

Medical Out-of-Pocket Maximum: a specified dollar amount of Medical Deductibles and Coinsurance to be paid per Covered Person in a Benefit Period for Covered Services for medical care as listed in the ***Summary Schedule of Benefits***. The Medical Deductible is included in the Medical Out-of-Pocket Maximum. The Medical Out-of-Pocket Maximum does not include reductions in benefits caused by not complying with the Plan's ***Utilization Management*** requirements, Claim Charges that exceed Eligible Charges, any Prescription Drug expenses, or any charges for any non-Covered Services. When the Medical Out-of-Pocket Maximum is reached for a Benefit Period, no additional Coinsurance is required for Covered Services for medical care for the remainder of the Benefit Period unless otherwise specified in this SPD.

Medical Out-of-Pocket Maximum Family Limit: the maximum dollar amount of Covered Expenses for medical care services listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period for all covered Members of your family.

Member: a Colleague who has met the eligibility requirements specified in the ***Eligibility*** section of this document, who is enrolled in the Plan, and whose coverage is in effect. Member also includes a Dependent that has met the eligibility requirements specified in the ***Eligibility*** section of this document, who is enrolled in the Plan and whose coverage is in effect. Member also includes a former Plan Member that has elected to continue coverage and has paid applicable premiums to do so under the Plan's ***Continuation of Coverage*** provisions.

Mental Illness: those illnesses classified as disorders in the current *Diagnostic and Statistical Manual of Mental Disorders* published by the American Psychiatric Association.

"Serious Mental Illness" means the following mental disorders as classified in the current *Diagnostic and Statistical Manual* published by the American Psychiatric Association:

(i) Schizophrenia;
(ii) Paranoid and other psychotic disorders;
(iii) Bipolar disorders (hypomanic, manic, depressive and mixed);
(iv) Major depressive disorders (single episode or recurrent);
(v) Schizoaffective disorders (bipolar or depressive);
(vi) Pervasive developmental disorders;
(vii) Obsessive–compulsive disorders;
(viii) Depression in childhood and adolescence;
(ix) Panic disorder;
(x) Post–traumatic stress disorders (acute, chronic, or with delayed onset); and
(xi) Anorexia nervosa and bulimia nervosa.

Minimum Essential Coverage: Health insurance coverage that meets the federal government's individual shared responsibility qualifications under the Affordable Care Act.

Morbid Obesity: a condition where a Covered Person has:

1. a weight at least 100 pounds over the ideal weight for frame, height, and gender as specified in the National Institutes of Health (NIH) guidelines;
2. a body mass index of at least thirty-five (35) kilograms per meter squared and with co-morbidity or coexisting medical conditions such as hypertension, cardiopulmonary conditions, sleep apnea, or severe diabetes; or
3. a body mass index of at least forty (40) kilograms per meter squared without co-morbidity.

Network: A group of Hospitals, Ambulatory Surgical Facilities, other facilities and Professional Providers that have a written agreement with the Claim Administrator to provide services for the exclusive provider option that applies to Covered Persons. The Network that applies to Covered Persons is based on the zip code of the primary home residence of the Subscriber.

If the Subscriber's primary home residence is included in the zip code list in Appendix A – Prevea 360 Network Service Area, the Subscriber and any Dependents covered under this SPD must use a Provider in the Prevea 360 ASO Network in order to receive benefits under this Plan. See ***Out of-Network Providers*** and ***Special Circumstances*** for information on when benefits may be covered for services received from an Out-of-Network Provider. To find a Network Provider in the Prevea 360 ASO Network, follow these steps:

1. Go to deancare.com/aso
2. Under "Find a Doctor", click "Please Select Your Insurance Network".
3. Select "Prevea 360 ASO Network" then choose "Select Your Health Plan" and select "ASO Network".
4. Enter your search criteria and follow the instructions to find a provider.

If the Subscriber's primary home residence is included in the zip code list in Appendix B, Prevea 360/HealthEOS Network Service Area, the Subscriber and any Dependents covered under this SPD must use a Provider in either the Prevea 360 ASO Network or HealthEOS Network in order to receive benefits under this Plan. See ***Out of-Network Providers*** and ***Special Circumstances*** for information on when benefits may be covered for services received from an Out-of-Network Provider. To find a Network Provider in the Health EOS Network, follow these steps:

1. Go to deancare.com/aso
2. Under "Find a Doctor", click "Please Select Your Insurance Network".
3. Select "HealthEOS & HealthEOS+" then choose "Health EOS Network" and press "Go" on the MultiPlan website.
4. Select "Health EOS" on the "Front of Card" section and press "Continue".
5. Enter your search criteria and follow the instructions to find a provider.

Covered Dependents whose primary residence is not included in either the zip code list in Appendix A or Appendix B whose out of area residence has been registered with DHP must use a provider in the Multiplan Network in order to receive benefits under this Plan.

Network Pharmacy: any licensed establishment in which the profession of pharmacy is practiced that has a written agreement with the Pharmacy Benefit Manager.

Network Provider: any Hospital, Ambulatory Surgical Facility, other facility or Professional Provider that has a written agreement with the Network that applies to the Member.

Network Specialist Physician (or Network Specialist): a Professional Provider who is not a Primary Care Physician that has a written agreement with the Network that applies to the Member.

New Colleague: You are considered a New Colleague for purposes of the Plan's Lookback Eligibility Method, if you did not work for the entire Standard Measurement Period for the Plan Year.

Non-Preferred Prescription Drugs: A Prescription Drug that is covered by the Plan but for which an additional Member Copay is required.

Nurse Practitioner: has the same meaning as Certified Nurse Practitioner.

Nutritional Counseling Services: services provided by a registered dietician (RD) to assess your current nutritional status and to provide education on proper nutritional practices to promote a healthy lifestyle and/or reduce or alleviate the effects of sickness.

Occupational Therapy: constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training.

Out-of-Network Provider: any Hospital, Ambulatory Surgical Facility, other facility, or Professional Provider that does not have a written agreement with the Network that applies to the Member.

Outpatient: treatment received while not an Inpatient. Services considered Outpatient, include, but are not limited to, services in an emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Partial Hospitalization Treatment Program: a planned program of a Hospital or Substance Abuse Treatment Facility for the Treatment of Mental Illness or Substance Abuse that provides Treatment for patients with mental or alcohol and other drug diagnoses, which do not require Inpatient services. These programs are time-limited and medically-monitored. They offer intensive, individually planned, comprehensive and structured services. Partial Hospitalization may be conducted during day or evening hours. It includes behavioral health groups, individual therapeutic sessions, family meetings, etc. to help the patient achieve the goals identified in an individualized treatment plan. Partial Hospitalization day or evening Treatment is less intensive than Inpatient services but more intensive than Outpatient services. Such programs typically offer group and individual therapy along with family counseling and medication management 4 or more days a week for a set number of hours per day.

Part-Time Colleague: If HSHS reasonably expects you to work less than 32 hours bi-weekly on a regular basis, HSHS will classify you as a Part-Time Colleague for purposes of the Plan's eligibility provisions.

Pharmacy Benefit Manager: Navitus Health Solutions.

Physical Therapy: the treatment of a disease, Injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training.

Physician: a medical doctor or surgeon (M.D.), a podiatrist (D.P.M.), an osteopath (D.O.), a psychologist (Ph.D.), a chiropractor (Doctor of Chiropractic), or a dentist or dental surgeon (D.D.S.), either licensed as required by the law of the state in which they practice, or in the absence of such law, recognized by the state association.

Physician Assistant: a duly licensed physician assistant performing under the direct supervision of a Physician, dentist or podiatrist and billing under such Provider.

Plan: the HSHS Healthy Plan

Plan Administrator: Hospital Sisters Health System.

Plan Sponsor: Hospital Sisters Health System

Plan Year: the calendar year.

Preferred Brand Name Drugs: medications included on the Navitus formulary and indicated by an "FB".

Preferred Drugs: medications included on the Navitus formulary and indicated by an "FB" or "FG".

Preferred Generic Drugs: medications included on the Navitus formulary and indicated by an "FG".

Prescription Legend Drugs or Prescription Drugs: medications that, by law, can be obtained only by a written or verbal order issued by a Physician or duly licensed Provider, practicing within the scope of his or her licensure, to a pharmacist and that bear the label, Caution: Federal law prohibits dispensing without a Prescription." and/or insulin.

Prescription Drug Deductible: the dollar amount of Covered Expenses listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period before benefits are payable under the Plan for Covered Services for Prescription Drugs.

Prescription Drug Deductible Family Limit: the maximum dollar amount of Prescription Drug Deductibles listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period for all covered Members of your family.

Prescription Drug Out-of-Pocket Maximum: a specified dollar amount of Prescription Drug Deductibles and Coinsurance to be paid per Covered Person in a Benefit Period for specified Covered Expenses for Prescription Drugs as listed in the ***Summary Schedule of Benefits***. The Prescription Drug Deductible is included in the Prescription Drug Out-of-Pocket Maximum. The non-Preferred Brand Name Drug copay applies to the Prescription Drug Out-of-Pocket Maximum. Non-Covered Services and the Ancillary Fee do not apply to the Prescription Drug Out-of-Pocket Maximum. When the Prescription Drug Out-of-Pocket Maximum is reached, no additional Coinsurance is required for the remainder of the Benefit Period for specified Covered Expenses for Prescription Drugs.

Prescription Drug Out-of-Pocket Maximum Family Limit: the maximum dollar amount of Covered Expenses for Prescription Drugs listed in the ***Summary Schedule of Benefits*** for which you are responsible each Benefit Period for all covered Members of your family.

Primary Care Physician (PCP): a Professional Provider who is a general practice Physician, a family practice Physician, an internal medicine Physician or a pediatric Physician. Nurse Practitioners and Physician Assistants who deliver services in conjunction with a Primary Care Physician are treated as Primary Care Physicians for purposes of the Plan's benefits.

Prior Authorization: the approval obtained from the Claims Administrator for certain services to be covered by the Plan. The approval must be received prior to the receipt of services.

Private Duty Nursing Services: Skilled Nursing Service provided on a one–to–one basis by an actively practicing registered nurse (R.N.), or licensed practical nurse (L.P.N.). Private Duty Nursing Service is shift nursing of 8 hours or greater per day and does not include nursing care of less than 8 hours per day. Private Duty Nursing Service does not include Custodial Care.

Professional Provider: a provider that is not a Hospital, Ambulatory Surgical Facility or other healthcare facility and that bills for services on a HCFA form rather than a UB form.

Provider: has the same meaning as Health Care Provider.

Qualified Medical Child Support Order (QMCSO): any judgment, decree or order (including approval of a settlement agreement) issued by a court of competent jurisdiction, which

(a) provides for child support with respect to a Subscriber's child under a group health plan or provides for health benefit coverage to such child, and is made pursuant to a state domestic relations law, including a community property law, and relates to benefits under such plan; or enforces a law relating to medical child support described in Section 1908 of the Social Security Act with respect to a group health plan; and

(b) clearly specifies:

   (i) the name and the last known mailing address, if any, of the Subscriber, and the name and mailing address of each child covered by the order;

   (ii) a reasonable description of the type of coverage to be provided by the group health plan to each child, or the manner in which such type of coverage is to be determined;

   (iii) the period to which such order applies; and each group health plan to which such order applies; and

(c) does not require a group health plan to provide any type or form of benefit, or any option, not otherwise provided under the group health plan, except to the extent necessary to meet the requirements of a law relating to medical child support as described in Section 1908 of the Social Security Act.

Residential Treatment Center: a location where patients live in the facility because they are in need of long-term treatment. This type of facility is frequently designed to care for adolescents. Ongoing therapy and activities, as well as behavioral modification programs are provided. In many cases, the setting will resemble a home environment.

Respite Care Services: those services provided at home or in a facility to temporarily relieve the family or other caregivers (non–professional personnel) that usually provide or are able to provide such services to the Covered Person.

Rule of Parity: Under the Rule of Parity, you will be considered to have had a Break in Service if you have a period of at least four weeks during which you do not have an Hour of Service and the period without an Hour of Service is greater than your immediately preceding period of employment with the Employer.

Seasonal Colleague: If you are hired in a position customarily expected to work six months or less, beginning at approximately the same time annually, HSHS will classify you as Seasonal Colleague for purposes of the Plan's eligibility provisions.

Sickness: ill health, unrelated to employment, including mental health disorders, and chemical dependency (alcoholism, drug abuse).

Skilled Nursing Facility: has the same meaning as Extended Care Facility.

Skilled Nursing Service: those services provided by a registered nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Skilled Nursing Service does not include Custodial Care.

Specialist Physician (or Specialist): a Professional Provider who is not a general practice Physician, a family practice Physician, an internal medicine Physician or a pediatric Physician. Nurse Practioners and Physician Assistants who deliver services in conjunction with a Specialist Physician are treated as Specialist Physicians for purposes of the Plan's benefits.

Speech Therapy: the treatment for the correction of a speech impairment resulting from disease, trauma, congenital anomalies or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training.

Stability Period: The period of time following a Measurement Period for which a Colleague is determined to be *eligible* or *ineligible* for Plan coverage based on the ***Lookback Eligibility Method***. For additional information see Initial Stability Period and Standard Stability Period.

Standard Measurement Period: For Plan Years beginning on and after January 1, 2017, the 12 month period ending each October 15th preceding the Plan Year. For the 2017 Plan Year, the Standard Measurement Period began October 16, 2015 and ended October 15, 2016.

Standard Stability Period: The Plan Year.

Subscriber: an eligible Colleague or former Colleague enrolled under the Plan, whose benefits are in effect. A Subscriber also includes beneficiaries under the Plan's ***Continuation of Coverage*** provisions that have elected to continue coverage and have paid applicable premiums to do so.

Substance Abuse: the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring medical care as determined by a Physician or psychologist.

Substance Abuse Treatment Facility: a facility (other than a Hospital) whose primary function is the treatment of Substance Abuse and is licensed by the appropriate state and local authority to provide such service. It does not include half–way houses, boarding houses or other facilities that provide primarily a supportive environment, even if counseling is provided in such facilities.

Summary Plan Description (or SPD): with respect to the HSHS Healthy Plan for Eastern Wisconsin colleagues, this document.

Surgery: the performance of any medically recognized, non–Investigational surgical procedure including the use of specialized instrumentation and the correction of fractures or complete dislocations and any other procedures as reasonably approved by the Claim Administrator.

Treatment: any medical, surgical, mental health or diagnostic intervention, or any drug, which is performed or given to improve or stabilize a medical condition.

Variable Hour Colleague: If you are not regularly scheduled to work at least 32 hours bi-weekly for the Employer and the Employer can't reasonable know when you become a Colleague or when you return to work after a Break in Service whether you will average at least 30 Hours of Service per week over the Initial Measurement Period, you are a Variable Hour Colleague.

ELIGIBILITY

ELIGIBLE COLLEAGUES

To be eligible for coverage described in this SPD, you must meet **all** of the following qualifications:

1. You must be a Colleague of one of the following:
   - St. Elizabeth's Hospital
     Belleville, Illinois
   - St. Joseph's Hospital
     Breese, Illinois
   - St. Mary's Hospital
     Decatur, Illinois
   - St. Anthony's Memorial Hospital
     Effingham, Illinois
   - St. Joseph's Hospital
     Highland, Illinois
   - St. Francis Hospital
     Litchfield, Illinois
   - St. John's Hospital
     Springfield, Illinois
   - Holy Family Hospital
     Greenville, Illinois
   - St. Joseph's Hospital
     Chippewa Falls, Wisconsin
   - Sacred Heart Hospital
     Eau Claire, Wisconsin
   - St. Mary's Hospital Medical Center
     Green Bay, Wisconsin
   - St. Vincent Hospital
     Green Bay, Wisconsin
   - St. Clare Memorial Hospital
     Oconto Falls, Wisconsin
   - St. Nicholas Hospital
     Sheboygan, Wisconsin
   - HSHS Medical Group, Inc.
     Springfield, Illinois
   - HSHS Wisconsin Medical Group, Inc.
     Springfield, Illinois
   - Prairie Cardiovascular Consultants, Ltd.
     Springfield, Illinois
   - Prairie Education and Research Cooperative
     Springfield, Illinois
   - Hospital Sisters Health System (HSHS)
     Springfield, Illinois
2. You must be regularly scheduled (budgeted) to work 32 or more hours bi-weekly on a continuing basis or qualify under the Plan's ***Lookback Eligibility Method.*** You are eligible under the ***Lookback Eligibility Method*** during a Stability Period associated with a Plan Measurement Period during which you averaged 30 or more Hours of Service per week.
   - For the January 1, 2017 – December 31, 2017 Plan Year, if you became a Colleague on or before October 16, 2015, January 1, 2017 thru December 31, 2017 is your Stability Period, which is the Plan's Standard Stability Period. You are eligible to participate in the Plan during this Stability Period if you averaged 30 or more Hours of Service per week during the Plan's Standard Measurement Period of October 16, 2015 through October 15, 2016, provided you continue to be a Colleague and to make any required contributions toward your coverage.

- If you become a Colleague after October 16, 2015, your Initial Measurement Period begins on the first day of the month on or following the date you become a Colleague and ends on the last day of the month 12 months later. Your Initial Stability Period begins on the first day of the month one month following the end of your Initial Measurement Period. (For example, if you were hired on January 2, 2016, your Initial Measurement Period is February 1, 2016 through January 31, 2017. Your Initial Stability Period is March 1, 2017 through February 28, 2018. You are eligible to participate in the Plan during this Stability Period if you averaged 30 or more Hours of Service per week during your Initial Measurement Period of February 1, 2016 through January 31, 2017, provided you continue to be a Colleague and to make any required contributions toward your coverage.)
- For Plan Years beginning January 1, 2017 or later, the Plan's Standard Measurement Period is October 16 of the calendar year two years prior to the first day of the Plan Year through October 15 of the calendar year preceding the first day of the Plan Year. The Plan's Standard Stability Period is the Plan Year.

  For the January 1, 2017 – December 31, 2017 Plan Year, the Plan's Standard Measurement Period is October 16, 2015 through October 15, 2016. The Plan's Standard Stability Period is January 1, 2017 – December 31, 2017.

See the ***Lookback Eligibility Method*** sub-section at the end of this Eligibility section for additional information regarding the Plan's ***Lookback Eligibility Method.***

3. You are not a leased employee. Leased employees are not eligible to participate in the Plan.
4. Your primary home residence zip code must be included in either Appendix A or Appendix B.
5. You are not a carpenter or painter employed by St. John's Hospital in Springfield, Illinois who is a member of a collective bargaining unit. Carpenters and painters employed by St. John's Hospital in Springfield, Illinois who are members of a collective bargaining unit are not eligible to participate in this Plan.
6. You are not a Medical resident on St. John's Hospital in Springfield, Illinois payroll. Medical residents on St. John's Hospital in Springfield, Illinois payroll are not eligible to participate in this Plan; and

Coverage for Colleagues newly hired in a position regularly scheduled (budgeted) to work 32 or more hours bi-weekly are eligible to participate in the Plan beginning on the first day of the pay period following two full bi-weekly pay periods of Active Employment in that hours classification. In meeting this requirement, employment with an entity in which HSHS has an ownership interest that is identified below will be considered employment with HSHS for individuals that transfer to HSHS with no lapse in employment between that entity and an HSHS Affiliate that is identified in item 1 above.

The entities to which this provision applies are:

- Prevea Health

Individuals who transfer to an HSHS Affiliate from one of these entities, with no lapse in employment between that entity and HSHS, will be eligible to participate in this Plan on the date they become an HSHS Colleague if they have completed at least four full weeks of employment with that entity prior to the transfer and they meet the Plan's other eligibility requirements.

See the section titled ***Special Eligibility Provisions Applicable to HSHS Acquisitions*** if you became a Colleague of an HSHS Affiliate as a direct result of a business acquisition of HSHS.

Colleagues of St. Clare Memorial Hospital and Prairie Education and Research Cooperative were first eligible to participate in this Plan effective January 1, 2015. Colleagues of Holy Family Hospital were first eligible to participate in this Plan effective January 1, 2017. Employment with any of these entities prior to the date they were first eligible to participate in this Plan is considered HSHS employment for eligibility purposes under this Plan. The *Special Eligibility Provisions Applicable to HSHS Acquisitions* do **not** apply to these Colleagues. However, if an individual was a participant in the St. Clare Memorial Hospital medical plan, the Prairie Education and Research Cooperative medical plan or the Holy Family Hospital medical plan as a COBRA beneficiary or a coverage continuee under state coverage continuation provisions, the individual may enroll in this Plan's Continuation of Coverage for up to the lesser of:

(1) the remainder of their COBRA/state continuation period as of the date they were first eligible to participate in this Plan and

(2) 18 months, 29 months if the individual is Social Security disabled as of the date they were first eligible to participate in this Plan or becomes Social Security disabled within 60 days of the date they were first eligible to participate in this Plan.

DEPENDENT ELIGIBILITY

Your dependents eligible for coverage under the Plan include:

- Your spouse to whom you are legally married. Civil union partners and domestic partners are not eligible. As a Catholic entity, HSHS understands marriage as designed by God to be between one man and one woman, but is providing benefits under protest to spouses as defined and as required by the civil law.
- Each of your children up to the end of the month in which age 26 is attained.
- An unmarried physically or mentally disabled child of any age provided the disability began before he or she reached the limiting age for coverage by the Plan. The child must be incapable of self- sustaining employment. Coverage may continue for as long as the child remains disabled and dependent on you for financial support. You must provide proof of the disability within 30 days after the date he or she reaches the limiting age and periodically, if requested by the Plan Administrator or the Claim Administrator.

A "child" is your natural born child, stepchild, legally adopted child, child who is being adopted and is still within the adoption process, and a child for whom you are the legal guardian. A foster child can be considered a dependent when the adoption process is in progress. Coverage is also extended to a child of your child (your grandchild) for whom you have assumed responsibility. The grandchild must live in your home and be principally dependent on you for support and maintenance. When the grandchild's parent (your child) reaches the Plan's limiting age, eligibility for the grandchild ceases.

This Plan will honor any Qualified Medical Child Support Order (QMCSO) issued by a domestic relations court. QMCSOs will be referred to the HSHS Colleague Service Center.

If you and your spouse both work for an Affiliate, you may each enroll for coverage as a Colleague, or one of you may be enrolled as a dependent of your spouse. You may not be covered as both a Colleague and a dependent. If you have dependent children, only one of you may cover your children.

If you newly enroll a child or spouse who is not currently covered, you will be required to provide documentation of their relationship to you. This documentation will be of a form specified by the Plan Administrator.

LOOKBACK ELIGIBILITY METHOD

The Plan's Lookback Method works like this.

1. HSHS will measure your Hours of Service during the Plan's Measurement Periods.
2. If you average at least 30 Hours of Service a week during a Plan Measurement Period, you will be eligible for coverage under this Plan during the corresponding Stability Period.
3. If you qualify to be eligible for coverage for a Stability Period, you will be eligible for coverage for the entire Standard Stability Period, even if your hours or wages decrease during the Stability Period, so long as you remain a Colleague and continue to make any required contributions toward your coverage.

Here is an example:

Ann has 1642 Hours of Service from October 16, 2015 through October 15, 2016, which is more than 30 Hours of Service a week, on average, during the Plan's Standard Measurement Period for the January 1, 2017 – December 31, 2017 Plan Year. She is therefore considered eligible for benefits during the Plan's Standard Stability Period from January 1, 2017 through December 31, 2017 as long as she continues to be a Colleague and to make any required contributions toward Plan coverage.

Ongoing Colleagues

If you are not regularly scheduled to work 32 or more hours every two weeks, each year HSHS will calculate how many Hours of Service you worked during the Plan's Standard Measurement Period and will inform you if you are eligible for benefits prior to the Plan's next Standard Stability Period.

- For the January 1, 2017 – December 31, 2017 Plan Year, the Plan's Standard Measurement Period is October 16, 2015 – October 15, 2016. The Plan's Standard Stability Period is January 1, 2017 – December 31, 2017.
- For the January 1, 2018 – December 31, 2018 Plan Year, the Plan's Standard Measurement Period is October 16, 2016 through October 15, 2017. The Plan's Standard Stability Period is January 1, 2018 – December 31, 2018. Subsequent Plan Years follow this same schedule, the Standard Stability Period is the Plan Year; the Standard Measurement Period is October 16 of the calendar year two years prior to the first day of the Plan Year through October 15 of the calendar year preceding the first day of the Plan Year.

New Colleagues

You are considered a New Colleague for purposes of the Plan's ***Lookback Eligibility Method***, if you did not work for the entire Standard Measurement Period that applies to the Plan Year. As a new Colleague, HSHS will classify you as a Benefits Eligible Colleague, Variable Hour Colleague, Part-Time Colleague or Seasonal Colleague for this Plan's eligibility purposes.

If you are classified as a Benefits Eligible Colleague, the Plan's standard eligibility provisions, not the Lookback Eligibility Method, apply.

If you are classified as a Variable Hour Colleague, Part-time Colleague, or Seasonal Colleague, HSHS will measure your Horus of Service over an Initial Measurement Period to determine whether you average 30 Hours of Service or more a week. Your Initial Measurement Period will begin on the first day of the month following your first day of work and will end 12 months later.

- If you average 30 or more Hours of Service during your Initial Measurement Period, you will be eligible to participate in the Plan during your Initial Stability Period, which begins on the first day of the month one month following the end of your Initial Measurement Period. You will be notified that you are eligible and will be given an opportunity to elect coverage under the Plan.
- If you average less than 30 Hours of Service during your Initial Measurement Period, you will not be eligible for coverage under the Plan during your Initial Stability Period.
- Once you have worked an entire Standard Measurement Period, your eligibility for Plan coverage will be determined by your Hours of Service each Standard Measurement Period. However, if you were determined to be eligible for Plan coverage during your Initial Measurement Period, your Plan eligibility will continue through the end of your Initial Stability Period provided you continue to be a Colleague and continue to make any required contributions toward your coverage.

Changes in Job Classification during Your Initial Measurement Period
If you are hired as a Variable Hour, Seasonal or Part-Time Colleague, but during your Initial Measurement Period your job classification changes to Benefits Eligible Colleague, you will be eligible for coverage under this Plan on the first day of the pay period following two full bi-weekly pay periods in that classification or the first day of a Standard Stability Period associated with a Standard Measurement Period during which your Hours of Service averaged 30 or more per week if sooner.

If you are hired as a Benefits Eligible Colleague, but your job classification changes to Variable Hour Colleague, Part-time colleague, or Seasonal Colleague during your Initial Measurement Period, your Plan coverage/eligibility will cease on the date your job classification changes. Your Initial Measurement Period will be the period from the first day of the month following your first day of employment with the Employer through the end of the month 12 months later.

Changes in Job Classification following Your Initial Measurement Period
Following your Initial Measurement Period, if you are not eligible for coverage and your classification changes to Benefits Eligible Colleague, you will be eligible for coverage under this Plan on the first day of the pay period following two full bi-weekly pay periods in the Benefits Eligible Colleague classification or the first day of a Standard Stability Period associated with a Standard Measurement Period during which your Hours of Service averaged 30 or more per week if sooner.

If you are enrolled in Plan coverage and your hours classification changes, your contribution toward the cost of your coverage will change as of the first day of the pay period on or following your hours classification change to the amount applicable to your new hours classification.

Break in Service
If you experience a period of 13 consecutive weeks (or longer) without an Hour of Service – either because you terminate employment or are absent for some other reason you will have a break in Service and you will be treated as a New Colleague to the extent permitted by law. The Plan Administrator may, in its discretion, determine that you have a Break in Service using an alternate "Rule of Parity".

Rehires
If you terminate employment with the Employer, are rehired as a Variable Hour/Part-time/Seasonal Colleague and you did not have a Break in Service, you will be eligible for coverage under the Plan on the date you become a Colleague again, if you were eligible under the Plan's Lookback Eligibility Method provisions at the time of your termination of employment. You will be considered eligible for coverage under the Plan until at least the end of the Stability Period applicable to you at the time of your termination of employment.

If you terminate employment with the Employer, are rehired as a Benefits Eligible Colleague and you did not have a Break in Service, you will be eligible for coverage under the Plan on the date you become a Colleague again, provided you were eligible for coverage at the time of your termination of employment. If you were not eligible for coverage at the time of your termination of employment, you will be eligible to participate in the Plan no later than the first day of the pay period following two full bi-weekly pay periods of Active Employment in that status.

Eligibility Determinations are Made by Plan Administrator
It is solely within the authority of the Plan Administrator to determine whether you are eligible for coverage under this Plan. A person the Plan Administrator determines is not an eligible Colleague who is later required to be reclassified as an eligible Colleague will only be eligible prospectively, provided all other eligibility requirements are met.

FAILURE TO ENROLL WHEN FIRST ELIGIBLE

If you do not complete your Flexplan enrollment by the enrollment deadline that is stated in the enrollment instructions provided to you, you will be enrolled automatically into the Basic option for yourself only with after-tax deductions for your portion of the cost of this coverage.

ANNUAL ENROLLMENT

You may change your medical coverage during annual enrollment each year. If you do not change your election during an annual enrollment period, the coverage already in effect will continue, provided you still meet the Plan's eligibility requirements. However, your contribution amount will change to the amount communicated for the new year. The annual enrollment information provided by HSHS each year will specify the policies that apply if you do not make an election during the annual enrollment period.

WHEN COVERAGE BEGINS

Your coverage starts on the date you become eligible provided you enroll and authorize the required contributions on or before your enrollment deadline. You will not be able to make any changes to your election until the annual open enrollment period unless you experience a qualified change in status.

If you did not enroll when first eligible and later acquire a dependent, you and your dependent may enroll within 30 days of acquiring the dependent.

WHEN COVERAGE BEGINS FOR YOUR DEPENDENTS

Coverage for your Dependents begins on the same day as your coverage, provided you have enrolled them in the Plan and have authorized the required contributions.

Children to be adopted will be covered as soon as they are placed with the family. Placed for adoption does not mean coverage from birth.

If you acquire a Dependent (through marriage, birth, or adoption, for example) coverage for your Dependent will begin on the date you acquire the new Dependent provided that you apply for coverage for the Dependent within 30 days of acquiring the dependent. Additionally, if a Dependent loses other health insurance, coverage for your Dependent(s) will begin on the day following the date the other coverage terminates, provided you apply for coverage for the Dependent(s) within 30 days of the coverage loss.

Newborn physician and Hospital charges will be covered for the first 30 days if you are covered at the time of the child's birth. Unless you enroll the child in coverage within 30 days after the child's birth, the child will no longer be covered.

CHANGING YOUR HEALTH PLAN COVERAGE

Normally, you can only change your coverage during the annual enrollment period, which occurs at the end of each year. However, you also can enroll or change your dependent coverage status during the year if you experience a qualified "change in status."

A change in one of the following is considered a qualified status change:

- **Legal marital status change**, including marriage, death of a spouse, divorce, legal separation, or annulment for you or your child who meets the Plan's ***Dependent Eligibility*** requirements.
- **Change in the number of eligible children** including birth, adoption, placement for adoption, or death of a child that meets the requirements specified in the ***Dependent Eligibility*** section.
- **Change in work status for you, your spouse, your eligible child, or your eligible child's spouse** (e.g., termination or commencement of employment, reduction or increase in hours of employment, including a switch between part-time and full-time, a strike or lockout, or commencement or return from an unpaid leave of absence) when the change affects medical eligibility.
- **Your child satisfies or ceases to satisfy the Dependent Eligibility requirements** specified in the Dependent Eligibility section.
- **Your spouse, your eligible child, or your eligible child's spouse moves to an area where he/she is outside the service area for his/her employer's medical plan -** you may add your spouse and/or children eligible to participate in this Plan who were previously covered under that plan to this Plan.
- **Change in other medical coverage as a result of your spouse's employer's annual enrollment**
- If you and/or your Dependents become covered by or lose coverage through another medical plan as a result of your spouse's employer's annual enrollment which occurs at a different time than that of this Plan, you may change your HSHS Healthy Plan coverage accordingly. However, your election to change your coverage must be made within 30 days of when your spouse's medical coverage change becomes effective.
- **Change in other medical coverage as a result of your child's employer's annual enrollment or the annual enrollment of the employer of your child's spouse** - If your child who meets the Plan's ***Dependent Eligibility*** requirements becomes covered

by or loses coverage through another medical plan as a result of his/her employer's annual enrollment or his/her spouse's employer's annual enrollment which occurs at a different time than that of this Plan, you may change your HSHS Healthy Plan coverage accordingly. However, your election to change your coverage must be made within 30 days of when your eligible child's medical coverage change becomes effective.

- **Significant change in the cost of medical coverage** under this Plan or a plan available through your spouse's employer, eligible child's employer, or employer of your eligible child's spouse.
- **Significant change in the medical coverage available** through your spouse's employer, eligible child's employer, or employer of your eligible child's spouse.

- If you are enrolled in Plan coverage and your hours are reduced to less than 30 per week from regularly scheduled 30 or more per week or you averaged 30 or more hours per week during the Measurement Period applicable to your current Stability Period, you can discontinue coverage under this Plan for yourself and any enrolled Dependents provided you intend to enroll yourself and any Dependents currently enrolled in this Plan in another plan that provides Minimum Essential Coverage.
- If you are enrolled in Plan coverage and your hours classification changes resulting in a significant increase in your cost of coverage, you may change your election to a less expensive Plan option for yourself and any enrolled Dependents.

If a change in status meets one of the circumstances listed above, an election change is allowed *only* if it meets one of the following consistency requirements.

- The change in status results in the Colleague or Dependent gaining or losing eligibility for health coverage under this Plan or a health plan of another employer. This includes becoming eligible or ineligible for a particular benefit package option (such as a managed care option); ***and*** the election change corresponds with that gain or loss of coverage.

  or
- The change results in a significant change in the cost of coverage under this Plan or a health plan of another employer ***and*** the election change corresponds with that change in cost.

  or
- You are enrolled in this Plan, your Hours of Service change from 30 or more per week to less than 30 Hours of Service per week, and you intend to enroll yourself and any enrolled Dependents in another plan that provides Minimum Essential Coverage.

To change your health insurance election due to a status change, complete and submit the necessary forms to your People Services Department within 30 days of the date of the status change. If you newly enroll a child or spouse, you must provide documentation of their relationship to you.

A coverage change becomes effective on the date the new enrollment is accepted by the Plan Administrator.

SPECIAL ENROLLMENT PERIODS

If you decline coverage for yourself or your Dependent(s) because of other health insurance coverage and that coverage ends, you may enroll yourself and/or your eligible Dependents in one of the Plan options provided:

a) you are eligible for coverage at that time;
b) if the other health insurance coverage was COBRA continuation coverage, such coverage has been "exhausted";
c) if the other health insurance coverage was not COBRA continuation coverage, employer contributions toward the cost of such coverage have terminated or the individuals covered under the other health insurance coverage cease to be eligible for that coverage; and
d) you request enrollment within 30 days after the other coverage ends.

In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your eligible Dependent(s), provided you are eligible for coverage at that time and request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

If you or your eligible Dependents are not enrolled in the Plan and lose Medicaid or Children's Health Insurance Program (CHIP) coverage or you or your eligible Dependents become eligible for medical coverage premium assistance through a state program, you may enroll yourself and your eligible Dependents in one of the Plan's options, provided you are eligible for the Plan at that time and request enrollment within sixty (60) calendar days after the date Medicaid or CHIP coverage is lost or the date state medical coverage premium assistance becomes available.

If you are already enrolled in a Plan option when you acquire a new Dependent or your Dependent loses other health coverage, you may choose any of the available options, if you decide to enroll that Dependent. The option you elect will apply to you and all eligible Dependents that you enroll. If you choose a different option than the one in which you were previously enrolled, any amounts applied to the annual Medical Deductibles, Prescription Drug Deductible, Medical Out-of-Pocket Maximums, and Prescription Drug Out-of-Pocket Maximum of the option in which you were enrolled will be credited to the applicable annual deductibles and out-of-pocket maximums of the new option in which you enroll. If the amount applied to the annual deductibles or out-of-pocket maximums under an option in which you were previously enrolled exceeds the amount applicable to a new option you elect, you will be deemed to have met the requirement of the new option. The amount by which the new option's annual deductible or out-of-pocket maximum is exceeded is not refundable to you or payable to your healthcare Providers.

Coverage will be effective on the day following the date the other coverage terminated, or in the case of a newly acquired dependent, on the date the new dependent is acquired.

ANNUAL ENROLLMENT RULES

The following rules apply to changing your health plan coverage during the annual enrollment period:

- You may add or drop coverage for yourself or your Dependents during the annual

enrollment period. If you newly enroll a child or spouse, you must provide documentation of their relationship to you.

- During the annual enrollment period, you may change from your current option to any other Plan option.
- If you are currently enrolled in a Plan option and do not actively enroll or waive coverage during open enrollment, your Plan option and coverage level [Colleague only, Colleague + Child(ren), Colleague + Spouse, or Colleague + Spouse + Child(ren)] will continue at the new year's contribution amount.

Changes made during the annual enrollment period become effective on the following January 1.

TRANSFER POLICY

If you're covered by the Plan when you change employment from one Affiliate to another, your coverage will be continuous. You are not allowed to change your elections under this Plan if you transfer from one Affiliate to another.

MOVING INTO/OUT OF EASTERN WISCONSIN

Moving Out of Eastern Wisconsin

If you are enrolled in one of the Eastern Wisconsin HSHS Healthy Plan options and change your primary home residence from Eastern Wisconsin, as defined by the zip codes listed in Appendix A and Appendix B combined, to a location that is not within the list of defined Eastern Wisconsin zip codes, you and all of your covered Dependents will automatically be enrolled in the corresponding option and same coverage level under the terms outlined in the HSHS Healthy Plan Summary Plan Description (SPD). Coverage for you and all of your covered Dependents under the terms outlined in this SPD will terminate.

If you provide documentation to Aetna from DHP of the amounts applied to the Plan Year Medical Deductibles, Prescription Drug Deductible, Medical Out-of-Pocket Maximums, and Prescription Drug Out-of-Pocket Maximums while you and your Dependents were covered under an Eastern Wisconsin HSHS Healthy Plan option, these amounts will be credited to the applicable Plan Year deductibles and out-of-pocket maximums under the option you are enrolled under the terms of the HSHS Healthy Plan Summary Plan Description. You can request documentation from DHP directly by calling Customer Service at 1-888-895-1188 or by contacting the HSHS Colleague Service Center at 1- 855-394-4747 or fyi@hshs.org. You can provide the documentation from DHP directly to Aetna or ask the HSHS Colleague Service Center to do so for you. The documentation from DHP must be on DHP letterhead or in an email that can be identified as coming from DHP.

If DHP processes additional claims for you or your covered Dependents after you have provided documentation of your Plan Year deductibles and out-of-pocket maximums under the Eastern Wisconsin HSHS Healthy Plan option to Aetna, you must repeat the process outlined above in order to have any additional amounts credited to your Plan Year deductibles and out-of-pocket maximums under the option you are enrolled under the terms of the HSHS Healthy Plan Summary Plan Description.

Moving Into Eastern Wisconsin

If you are enrolled in a Healthy Plan option under the terms outlined in the HSHS Healthy Plan Summary Plan Description and your primary home residence changes to one in the defined list

of Eastern Wisconsin zip codes in Appendix A or Appendix B, you and all of your covered Dependents will automatically be enrolled in the corresponding option and same coverage level under the terms outlined in this SPD.

You can request documentation from Aetna of the Plan Year deductible and out-of-pocket amounts you and your covered Dependents have accrued under the terms of the HSHS Healthy Plan SPD by contacting Aetna Member Services at 1-800-345-9474 or the HSHS Colleague Service Center at 1-855-394-4747 or fyi@hshs.org. The Covered Person or HSHS Colleague Service Center must provide the deductible and out-of-pocket amounts to DHP so these amounts can be credited to the applicable Plan Year deductibles and out-of-pocket maximums under the option you are enrolled under the terms of this SPD. If Aetna processes additional claims for you or your covered Dependents after you have provided documentation of your Plan Year deductibles and out-of-pocket maximums under the HSHS Healthy Plan option to DHP, you must repeat the process outlined above in order to have any additional amounts credited to your Plan Year deductibles and out-of-pocket maximums under the option you are enrolled under the terms of this SPD.

THE COST OF YOUR COVERAGE

You and your employer share the cost of coverage under the Plan. Your contributions for coverage will be deducted from your paycheck on a before-tax basis under Flexplan, except in situations where you are automatically enrolled in the Basic option. If you are automatically enrolled in the Basic option because you do not provide proof of other coverage, your contributions will be deducted from your paycheck after-tax.

Using the before-tax method, your share of the cost of coverage is deducted from your pay before taxes are calculated and withdrawn. This benefits you because you pay no federal income or F.I.C.A. taxes, or state taxes in most states, on your insurance premium.

You should be aware that the use of salary reduction to purchase health care benefits may have a slight effect on the benefits you and your family will receive from Social Security at retirement or in the event of your disability or death. Social Security amounts are determined using a formula that takes your
F.I.C.A. .A. taxable income into account. When you convert a portion of your pay
with salary reduction, you reduce your F.I.C.A. taxable income proportionately.

FAMILY LEAVE OR MEDICAL LEAVE

If a Covered Person who is a Subscriber is on a family leave or medical leave of absence, coverage will continue under the policy, in accordance with the Plan Sponsor's policy on family and medical leaves of absence, as if the Colleague was in Active Employment, if the following conditions are met:

- the required premiums are paid by the Colleague; and
- the Employer has approved the Colleague's leave in writing.
- Coverage under the Plan for the Covered Person who is the Subscriber and any covered Dependents will be continued for up to the greater of:
  - the leave period required by the federal Family and Medical Leave Act of 1993, and any amendment;
  - the leave period required by applicable state law; or
  - if applicable, the period during which the Colleague is approved to receive short-

term disability or Extended Illness Benefits due to his/her own illness or Injury.

Coverage under the Plan will begin immediately upon return to work even if the premium (coverage) was not continued during the period of leave.

A Colleague taking an approved medical leave of absence for his/her own serious health condition will pay the colleague rate for health insurance for a maximum of 26 weeks. Following that period, the Colleague may continue coverage under the Plan's ***Continuation of Coverage*** provisions. A Colleague taking an approved Family Medical Leave of absence other than for his/her own serious health condition will pay the Colleague rate for health insurance for the duration of the leave's approval, up to a maximum of 12 weeks, whichever occurs first. Following that period, the Colleague may continue coverage under the Plan's ***Continuation of Coverage*** provisions.

A Colleague on an approved leave of absence for any other reason must pay the full premium amount for health insurance for the leave's approved duration. Premiums must be received at the beginning of the period for which they are due.

SPECIAL ELIGIBILITY PROVISIONS APPLICABLE TO HSHS ACQUISITIONS

For purposes of this section, *actively at work* means that an employee is present at his or her employer's normal place of business, or at another place that the employer's business requires him or her to travel, fully performing his or her customary duties for his or her regularly scheduled hours. An employee is considered *actively at work* if absent on a non-work day, provided he or she was *actively at work* on his or her last scheduled work day immediately preceding the non-work day. Non-work days are days that an employee is not regularly scheduled to work, including scheduled time off for vacations, personal holidays, weekends and holidays.

Individuals Actively at Work on Last Day of Acquired Entity

Individuals that become Colleagues of an Affiliate as a direct result of a business acquisition of HSHS are eligible to participate in the HSHS Healthy Plan on the date the individual becomes an HSHS Colleague, provided that:

(1) the Colleague meets the Plan's eligibility requirements, other than the Plan's employment period requirement,

(2) there is no lapse in employment between the entity being acquired and the Affiliate, and

(3) the individual was *actively at work* on the last day that the acquired entity was in existence and is either:

  (a) present on his/her first scheduled work day with the HSHS Affiliate or

  (b) absent from work on his/her first scheduled work day with HSHS due to his/her own illness or Injury or due to a leave qualified under the Family and Medical leave Act of 1993 (FML) or a leave period required by applicable state law.

Individuals that enroll in the HSHS Healthy Plan under this provision may also enroll any Dependent that meets the ***Dependent Eligibility*** provisions of this Plan.

Individuals Enrolled in Acquired Entity's Plan on last Day of the Acquired Entity's Existence Who Do Not Meet HSHS Healthy Plan Eligibility Requirements

If a business that HSHS acquires sponsors a group health plan that provides medical and/or

prescription drug benefits on the date immediately preceding the HSHS acquisition date (*acquired entity's plan*), the following provisions apply to individuals enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence that lose access to that coverage who are not otherwise eligible to participate in the HSHS Healthy Plan:

A. If the individual was a participant in the *acquired entity's plan* as a COBRA beneficiary or a coverage continuee under state coverage continuation provisions, the individual may enroll in HSHS Healthy Plan ***Continuation of Coverage*** for up to the lesser of:
   (1) the remainder of their COBRA/state continuation period as of the HSHS acquisition date and
   (2) 18 months, 29 months if the individual is Social Security disabled as of the acquisition date or becomes Social Security disabled within 60 days of the acquisition date.

B. If the individual was a participant in the acquired entity's plan as an actively at work employee of the acquired entity or a dependent child, the individual may enroll in HSHS Healthy Plan ***Continuation of Coverage*** for up to the lesser of:
   (1) 18 months or
   (2) 29 months if the individual is Social Security disabled as of the acquisition date or becomes Social Security disabled within 60 days of the acquisition date.

   Individuals who were participants in the *acquired entity's plan* as an *actively at work* employee that enroll in the HSHS Healthy Plan under this provision may also enroll any dependent who was enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence.

C. If the individual is an employee of the acquired entity that is off work due to his or her own illness or Injury on the last day the acquired entity is in existence and the individual has been off work for this reason for less than 26 weeks, the individual may enroll in HSHS Healthy Plan coverage as of the acquisition date:
   (1) For the remainder of the 26 week period, if any, from the first day of absence due to personal illness or Injury (including the time off work under the prior entity) provided that he or she pays the premium contribution amount that applies to active employees of the HSHS Affiliate.
   (2) Once 26 weeks from the first day of absence due to personal illness or Injury (including the time off work under the prior entity) has elapsed, provided that the individual has maintained coverage throughout the entire period he or she has been absent from work due to his or her personal illness or Injury, the HSHS Healthy Plan's ***Continuation of Coverage*** provisions apply.

   Individuals who enroll in the HSHS Healthy Plan under this provision may also enroll any Dependent that was enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence, provided that the Dependent meets the ***Dependent Eligibility*** provisions of this Plan.

D. If the individual is an employee of the acquired entity that is on a leave qualified under the Family and Medical Leave Act of 1993 (FML) or a leave period required by applicable state law as of the last day the acquired entity is in existence, the individual may enroll in HSHS Healthy Plan coverage as of the acquisition date:

(1) For the remainder of the FML or state leave period, if any, provided that he or she pays the premium contribution amount that applies to active employees of the HSHS Affiliate.

(2) Once the FML or state leave period has expired, provided that the individual has maintained coverage throughout the entire qualified leave period, the HSHS Healthy Plan's ***Continuation of Coverage*** provisions apply.

Individuals who enroll in the HSHS Healthy Plan under this provision may also enroll Dependents that meet the ***Dependent Eligibility*** provisions of this Plan.

E. If the individual is an employee of the acquired entity that is on an approved leave as of the last day the acquired entity is in existence that is not a qualified leave under the Family and Medical Leave Act of 1993 (FML), not a leave period required by applicable state law, and not a leave due to his or her own personal illness or Injury, the individual may enroll in HSHS Healthy Plan coverage as of the acquisition date for the remainder of the approved leave period, but no longer than one year from the first day of the approved leave, provided that he or she pays the premium contribution amount that applies to active employees of the HSHS Affiliate. Individuals who enroll in the HSHS Healthy Plan under this provision may also enroll any dependent that was enrolled in the acquired entity's plan as of the last day of the acquired entity's existence, provided that the Dependent meets the ***Dependent Eligibility*** provisions of this Plan.

F. If the individual is a retiree of the acquired entity who is under age 65 and not eligible for Medicare, the individual may enroll in HSHS Healthy Plan coverage as of the acquisition date under the Plan's ***Continuation of Coverage*** for the remainder of the coverage period provided under the *acquired entity's plan*, but not past age 65 or attainment of Medicare eligibility, if earlier. An early retiree that enrolls in Healthy Plan under this provision may also enroll any Dependent who was enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence, provided that the Dependent meets the ***Dependent Eligibility*** provisions of this Plan.

G. If the individual is a retiree of the acquired entity who is age 65 or older or who is eligible for Medicare, the individual may **not** enroll in HSHS Healthy Plan coverage.

Individuals on FML/State Leave Who are Not Enrolled in Acquired Entity's Plan on Last Day of the Acquired Entity's Existence

Individuals that are on a leave qualified under the Family and Medical Leave Act of 1993 (FML) or a leave period required by applicable state law as of the last day the acquired entity is in existence who are not enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence may enroll in HSHS Healthy Plan coverage as of the acquisition date for the remainder of the FML or state leave period, if any, provided that he or she pays the premium contribution amount that applies to active employees of the Affiliate. If the individual maintains coverage under this Plan through the end of the qualified FML or state leave period, once the qualified leave period expires, the Plan's ***Continuation of Coverage*** provisions apply. Individuals who enroll in the HSHS Healthy Plan under this provision may also enroll any Dependent that meets the ***Dependent Eligibility*** provisions of this Plan.

Individuals on Other Approved Leave Who are Not Enrolled in Acquired Entity's Plan on Last Day of the Acquired Entity's Existence

An individual who is not enrolled in the *acquired entity's plan* and who is off work on an approved leave as of the last day the acquired entity is in existence:

(1) May enroll in the HSHS Healthy Plan on his or her first day *actively at work* with an HSHS Affiliate, provided his or her first day *actively at work* with HSHS is no more than 26 weeks after the first day off work for this approved leave.

(2) May enroll in the HSHS Healthy Plan after fulfilling the Plan's standard eligibility requirements, including the Plan's employment period requirement, if his or her first day *actively at work* with HSHS is more than 26 weeks after the first day off work for this approved leave.

Individuals who enroll in Healthy Plan under this provision may also enroll any Dependent that meets the ***Dependent Eligibility*** provisions of this Plan.

In all cases, coverage under the Plan's ***Continuation of Coverage*** is subject to the following:

- The Plan's ***Termination Of Continuation Of Coverage*** provisions and
- Premiums must be paid totally by the Covered Person and the full premium payment must be received by the beginning of each pay period.

Any out-of-pocket expenses incurred by an individual under the *acquired entity's plan* do not apply to the HSHS Healthy Plan's deductibles or maximum out-of-pocket limits.

UTILIZATION MANAGEMENT SERVICES

The Claim Administrator has established the Utilization Management Program to assist you in determining the course of Treatment that will maximize your benefits under the Healthy Plan.

PRIOR AUTHORIZATION REQUIRED

The Utilization Management Program requires notification and opportunity to review supporting medical documentation of Covered Services for the following before such services are rendered. Medically urgent pre-service requests will be processed and a determination decision made within 72 hours following DHP receiving the request:

- Inpatient Hospital services (including any maternity stay longer than 48 hours following a vaginal delivery and 96 hours following cesarean. Urgent or emergent stays do not require a prior-authorization, but do require notification within 24 hours or the next business day.)
- Hospital observation stays
- Outpatient surgery procedures identified as requiring Prior Authorization in DHP's medical policies at deancare.com/ASO/members/aso-medical-management/
- Bariatric programs and surgery
- Skilled Nursing Facility services
- Coordinated Home Care services
- Private Duty Nursing services
- Durable Medical Equipment (DME) items over $500 (including prosthetics and orthotics)
    - Oxygen does not require prior authorization
- Physical and Occupational Therapies (after 8th visit)
- Speech Therapy (after initial visit)
- Pulmonary rehabilitation greater than 24 visits
- Procedures that may be considered cosmetic in nature
- Home infusion
- Hospice services
- Organ and tissue transplant related services
- Genetic Testing
- Non-emergent ambulance transport
- Outpatient pain-management services (including epidural steroid injections)
- New technologies not commonly accepted as standard of care
- Medical professional administered drugs, please see deancare.com/asoinjectables for a complete list
- All Out-of-Network Provider services
- Partial hospitalization
- Outpatient radiology procedures, including CT, MRI, MRA and PET scan, nuclear exercise tolerance test (ETT), see deancare.com/providers/patient-care/radiology-prior-authorization/
- Clinical trials

- Enteral feedings
- Outpatient hyperbaric chamber
- Prophylactic Mastectomy

Failure to contact the Claim Administrator as required or to comply with the determinations of the Claim Administrator will result in a reduction in benefits. If your Network Provider participates in the Prevea 360 ASO Network and does not comply with the Prior Authorization requirement, the Network Provider cannot bill you or the Plan for the services provided. If your Network Provider participates in the HealthEOS or Multiplan network and does not comply with the Prior Authorization requirement, after the standard benefits payable under this Plan are calculated, the benefits are reduced by 30%. The reduction of the Claim, for which you are responsible, cannot be used to satisfy the annual Medical Deductibles or the annual Medical Out-of-Pocket Maximums. The toll–free telephone number for medical pre–notification is on your identification card –
1-888-895-1188. Please read the remaining provisions of this section very carefully.

If you receive services from an Out-of-Network Provider before receiving Prior Authorization from the Claims Administrator, no benefits will be payable by the Plan for these services.

Prior Authorization is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Healthy Plan.

- **Inpatient Hospital and Skilled Nursing Facility Prior Authorization Review** - Whenever a non-emergency or non-maternity Inpatient Hospital admission or Skilled Nursing Facility admission is recommended by your Physician, in order to receive maximum benefits under this Plan, you or someone on your behalf must call the Claim Administrator's prior authorization number. Scheduled admissions require Prior Authorization from the Plan. If any Emergency Accident results in a Hospital Admission to an Out-of-Network Hospital, you or the Hospital must call DHP by the next business day following the admission. Failure to notify DHP, when notification is reasonably possible, could result in you being financially responsible for all, or part, of the services. If notification was not reasonably possible by the next business day following admission, your claim will not be prejudiced.

  If the proposed Hospital admission or health care services are determined to be not Medically Necessary, some days, services or the entire hospitalization will be denied. The Hospital and your Physician will be advised verbally of this determination and a follow–up notification letter will be sent to you, your Physician and the Hospital. These letters may not be received prior to your scheduled date of admission.

- **Emergency Admission Review -** In the event of an emergency admission, in order to receive maximum benefits under the Plan, you or someone who calls on your behalf must notify the Claim Administrator within 24 hours or by the next business day following admission.

- **Pregnancy/Maternity Admission Review** - In the event of a maternity admission, in order to receive maximum benefits under the Plan, you or someone who calls on your behalf must notify the Claim Administrator within 24 hours or by the next business day after the admission has occurred. If the call is made any later than the specified time period, you may not be eligible for maximum benefits.

- **Coordinated Home Care Prior Authorization -** Whenever Coordinated Home Care services are recommended by your Physician, in order to receive maximum benefits

u nder this Plan, you must call the Claim Administrator's medical prior authorization.

number. This call must be made at least one business day prior to the scheduling of the services.

The final decision regarding Treatment and hospitalization is yours. Maximum allowable Plan benefits are paid as long as these steps are followed prior to any inpatient hospitalization, Skilled Nursing Facility admission or receipt of Private Duty Nursing Services or partial hospitalization services.

LENGTH OF STAY/SERVICE REVIEW

Length of stay/service review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Healthy Plan.

Upon completion of the preadmission or emergency review, the Claim Administrator will notify your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that a length of stay was approved or the length of stay was denied. A denial will be issued both verbally and in writing with a written copy being issued to the Hospital and the Member.

An extension of the length of stay/service will be based solely on whether continued Inpatient care or other health care service is Medically Necessary. In the event that the extension is determined not to be Medically Necessary, the authorization will be denied. Notification will be provided to your Physician and/or the Hospital regarding the denial of payment for the extension both verbally and in writing.

CASE MANAGEMENT

Case management assists you with the coordination of complex care services. A Claim Administrator case manager is available to you as an advocate for cost–effective interventions.

Case Management is free of charge and provides you with a registered nurse who serves as your resource during a time when health care may be challenging or confusing. Your case manager will work with you, your health care provider and other members of the health care team as needed to establish your best plan of care. You may be identified for Case Management based upon a diagnosis, acute injury or from a referral by your health care provider. You also have the option to request Case Management services yourself.

Case Management staff will:

- Ensure you receive the most appropriate health-related services for your condition.
- Create the best plan of care for you in collaboration with your provider and health care team
- Identify high-quality, cost-effective care options
- Find supportive health care and/or community resources
- Offer support and resources to meet your healthcare goals
- Provide education and outreach services to promote a healthy lifestyle

Case managers will coordinate and implement the case management program, offering guidance and information on available resources and suggesting the most appropriate alternatives. Case management is a complimentary service and participation by the patient or patient's family is voluntary.

UTILIZATION MANAGEMENT PROCEDURES

The following information is required when you contact the Claim Administrator:

1. The name of the patient and relationship to the covered Subscriber
2. The name, employee ID number, and address of the covered Subscriber
3. The name of the Employer (HSHS)
4. The name and telephone number of the attending Provider
5. If the requested service is an inpatient admission, the name of the facility, proposed date of admission, and proposed length of stay
6. The proposed medical services
7. The proposed Provider who will render the requested medical services

The Utilization Management administrator will determine the number of days of inpatient confinement or use of other listed medical services authorized for payment. DHP will notify the Hospital, Provider and the Member in writing once an inpatient stay is no longer deemed Medically Necessary or a service is not Medically Necessary.

If you or your Physician disagree with the determination of the Claim Administrator prior to or while receiving services, you may appeal that decision. You should call the Claim Administrator's customer service number on your ID card. Your Physician should use the contact information in the notification letter.

In some instances, the resolution of the appeal process will not be completed until your admission or service has occurred and/or your assigned length of stay/service has elapsed. If you disagree with a decision after claim processing has taken place or upon receipt of the notification letter, you may appeal that decision by having your Physician call the contact person indicated in the notification letter or by submitting a written request to:

DHP Administrative Services
PO Box 1808
Grapevine, TX 76099-1808

See ***Claim Filing and Appeals Procedures*** for additional information regarding appeals.

SECOND AND/OR THIRD OPINION PROGRAM

The Plan covers a second surgical opinion following a recommendation for elective surgery if the service is received from a Network Provider. If an Out-of-Network provider is used, you must receive Prior Authorization from the Claims Administrator in order for benefit to be paid by the Plan. An elective surgery is one that can be scheduled in advance; that is, it is not an emergency or of a life threatening nature. Benefits for the second opinion will be paid as any other Sickness. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first consultation.The Member may

choose a Network Provider in the appropriate specialty. If a Network Provider in the appropriate specialty is not available, an Out-of-Network provider is covered, with Prior Authorization by DHP. The final decision of undergoing Surgery and the selection of a Physician to perform Surgery is entirely up to the Covered Person.

MEDICALLY NECESSARY DETERMINATION

The decision that Inpatient care or other health care services or supplies are or are not Medically Necessary will be determined by the Claim Administrator. The Claim Administrator will provide notification of a decision to not authorize payment for Inpatient care or other health care services or supplies to you, your Physician, and/or the Hospital or other Provider. The notification will specify the dates, services and/or supplies that are not considered Covered Services.

The Claim Administrator does not determine your course of Treatment or whether you receive particular health care services. Decisions regarding the course of Treatment and receipt of particular health care services are a matter entirely between you and your Physician. The Claim Administrator's determination of Medically Necessary care is limited to merely whether a proposed admission, continued hospitalization or other health care service is a Covered Service under the Healthy Plan.

In the event that the Claim Administrator determines that all or any portion of an Inpatient hospitalization or other health care service is not Medically Necessary, the Plan will not be responsible for any related Hospital or other health care service charge incurred.

Remember that the Plan does not cover the cost of hospitalization or any health care services and supplies that are not determined to be Medically Necessary. The fact that your Physician or another health care Provider may prescribe, order, recommend or approve a Hospital stay or other health care service or supply does not of itself make such hospitalization, service or supply Medically Necessary. Even if your Physician prescribes, orders, recommends, approves, or views hospitalization or other health care services or supplies as Medically Necessary, the plan will not pay for the hospitalization, services or supplies unless the Claim Administrator determines it to be Medically Necessary and a Covered Service under the Healthy Plan.

NOTE: Keep in mind that a Medically Necessary determination does not guarantee that benefits are available. For example, it might be determined that a service is Medically Necessary; however, the Plan may limit or exclude that service. In that case, the Medically Necessary determination does not override the Plan's applicable benefit as outlined in this SPD.

COVERED SERVICES

Covered Expenses include Eligible Charges incurred for the Medically Necessary services and supplies described in this section. Benefits are only provided when you receive services on or after your Coverage Date and prior to your coverage termination date.

Please refer to the ***Definitions, Eligibility,*** and ***Exclusions and Limitations*** sections of this Summary Plan Description for additional information regarding limitations and/or special conditions that pertain to your benefits.

Acupuncture – when performed by a Physician or prescribed by a Physician and a letter of Medical Necessity is provided prior to the receipt of acupuncture services.

Allergy Shots and allergy services, including allergy testing and allergy serum.

Ambulance – Professional ambulance to and from the Hospital. Transportation by air or rail is also covered provided:

- It is a Medical Emergency,
- Treatment is not available locally,
- Treatment is ordered by a Physician,
- Travel is to the nearest Hospital providing the necessary Treatment, and
- Travel is within the United States.

Benefits will not be provided for long distance trips or if the use of an ambulance is not Medically Necessary, even if more convenient than other transportation.

Ambulatory Surgical Center Services. Payment for Covered Expenses for services rendered by an Ambulatory Surgical Facility will be paid as if the services were rendered by a Hospital.

Amino Acid–Based Elemental Formulas - Benefits will be provided for amino acid–based elemental formulas for the diagnosis and treatment of eosinophilic disorders or short–bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid–based elemental formula is Medically Necessary.

Anesthetics and their administration by a Physician other than the operating surgeon, including services of a licensed Certified Registered Nurse Anesthetist (C.R.N.A.), when administered at the same time as a covered surgical procedure. In addition, anesthesia administered in connection with a Covered Service for Dental Treatment rendered in a Hospital or Ambulatory Surgical Facility for (a) a child age 6 or under or (b) a Covered Person with a chronic disability or other medical condition that requires Hospitalization or general anesthesia for dental care.

Applied Behavioral Analysis (ABA) Therapy for the treatment of Autism Spectrum Disorder(s) when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by a Physician, a psychologist, or a certified, registered or licensed health care professional with expertise in testing and in the use of empirically validated tools specific for Autism Spectrum Disorder(s) and when such care is determined to be medically necessary. The Plan reserves the right to require a second opinion with a provider mutually agreeable to the Member and the Claims Administrator.

For ABA services to be covered, a formal treatment plan must be developed and submitted to the Claims Administrator before treatment begins and annually thereafter. The treatment plan must include:

- The proposed treatment(s) by type; and
- The frequency of the proposed treatment(s); and
- The anticipated duration of the treatment(s); and
- The anticipated outcomes stated as individualized goals; and
- Objectives that are measurable and tailored to the patient; and
- Parent or caregiver training.

Intensive-level services include an average of 20 or more hours over a six-month period of time. The Plan limits coverage of intensive-level services to a maximum of four (4) years per Member. Any previous intensive-level services received by the Member apply toward this limit for purposes of this Plan, regardless of the payor. To be covered by the Plan, intensive-level services must be consistent with the following:

- Evidence-based.
- Provided by a qualified provider as defined by state law.
- Based on a treatment plan developed by a qualified provider or professional as defined by state law with specific cognitive, social, communicative, self-care or behavioral goals that are clearly defined, directly observed and continually measured. Treatment plans shall require that the Member be present and engaged in the intervention.
- Provided in an environment most conducive to achieving the goals of the Member's treatment plan.
- Include training and consultation, participation in team meetings and active involvement of the Member's family and treatment team for implementation of the therapeutic goals developed by the team.
- Commence after the Member is 2 years of age and before the Member is 9 years of age.
- Services must be assessed and documented throughout the course of treatment.
- The Member must be directly observed by the qualified provider at least once every two months.

Non-intensive-level services. The Member is eligible for non-intensive-level services, including direct or consultative services, that are evidence-based and are provided by a qualified provider or qualified paraprofessional if one of following conditions apply:

- After the completion of intensive-level services and designed to sustain and maximize gains made during intensive-level treatment.
- To a Member who has not and will not receive intensive-level services but for whom non-intensive level services will improve the Member's condition.

Non-intensive-level services must be consistent with the following:

- The services are based upon a treatment plan and includes specific therapy goals that are clearly defined, directly observed and continually measured and that address the characteristics of Autism Spectrum Disorders. Treatment plans shall require that the Member be present and engaged in the intervention.
- Implemented by qualified providers, qualified supervising providers, qualified professionals, qualified therapists or qualified paraprofessionals as defined by state law.
- Treatment and services are provided in an environment most conducive to achieving the goals of the Member's treatment plan.
- Provide training and consultation, participation in team meetings and active involvement of the Member's family in order to implement therapeutic goals developed by the team
- Provide supervision for qualified professionals and paraprofessionals in the treatment team.
- Services must be assessed and documented throughout the course of treatment.

Attention Deficit Disorder (ADD)

- To determine the diagnosis of ADD, the Plan will provide coverage for the following medical expenses:
  - Neurological Evaluation
  - EEG
  - Thyroid Panel
  - Glucose Tolerance Test
- Psychological Testing if the diagnosis is confirmed and the cause is medical in nature, the Plan will cover the facility's and Physician's Treatment.
- If the cause is psychological in nature, the appropriate Treatment by a covered Provider will be considered under the mental health coverage of the Plan.
- If the Treatment is educational, no benefits will be payable.

Biofeedback - Treatment received as part of a neuroscience program, performed as a result of a Physician's order in a Hospital controlled setting, if available, is covered.

Birthing Centers which are either part of a Hospital or are "free-standing" and provide care by a Certified Nurse-Midwife with supervision by a Physician or provided by a Physician and service by nurses with specialized training to monitor labor, delivery and after delivery family care.

Bone Mass Measurement and Osteoporosis – Routine bone density screening is covered under the ***Wellness and Preventive Care*** benefit for individuals meeting the criteria outlined in the ***Wellness and Preventive Care*** section. The Plan covers the Medically Necessary Treatment of osteoporosis under its standard provisions.

Blood (if not replaced) and Blood Derivatives (other than Blood derivatives which are not classified as drugs)

Cardiac Rehabilitation Services – Cardiac rehabilitation services in Claim Administrator approved programs are covered if you have a history of: acute myocardial infarction, coronary artery bypass graft Surgery, percutaneous transluminal coronary angioplasty, heart valve Surgery, heart transplantation, stable angina pectoris, compensated heart failure or transmyocardial revascularization.

Chemotherapy

Clinical Breast Exam – when performed by a Physician, Advanced Practice Nurse or Physician Assistant working under the direct supervision of a Physician.

Colonoscopies - Colonoscopies and sigmoidoscopies are covered under the Plan's wellness and preventive care provisions (see the ***Wellness and Preventive Care*** section).

Compression Stockings – Jobst stockings are covered, limit to 2 per plan year, and diagnosis must be medically appropriate

Contraceptives - Benefits will be provided for Prescription contraceptive drugs, devices, injections, implants and contraceptive services ***only when Medically Necessary***. A letter of Medical Necessity from the individual's Physician must be provided to the Claim Administrator for this benefit to apply. Birth control drugs, devices, injections, or implants whether or not dispensed by Prescription, which are purchased or prescribed ***for the sole purpose of preventing conception are not covered***.

Coordinated Home Health Care - Medically Necessary part-time or intermittent nursing care by, or under the supervision of, a registered nurse (R.N.), and associated supplies, furnished in the patient's home (which begins within 72 hours following a Hospital or Extended Care Facility confinement for the same or related condition), up to 120 visits in a calendar year.

Each home health visit (Skilled Nursing, Physical Therapy, Occupational Therapy, or Speech Therapy) for a Covered Person will be considered one home health visit.

Dental Treatment or Service - Only the following are covered:

- Medically Necessary Hospital confinement;
- Repair of damage to the jaw, cheek, lip, tongue, roof or floor of the mouth, or sound natural teeth as a result of an accident. Excision of tumors or cysts from the jaws, cheeks, lips, tongue, roof and floor of the mouth;
- Excision of exostoses of the jaws and hard palate (provided that this procedure is not done in preparation for dentures or other prostheses);
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands or ducts;
- Reduction of, dislocation of, or excision of the temporomandibular joints;
- Extraction or excision of impacted teeth (see ***Coordination with HSHS Dental Plan***);
- Surgical intervention of the correction of temporomandibular joint dysfunction syndrome (TMJ);
- Treatment of fractures of facial bones.

Diabetic Education - Outpatient self-management training, education, and nutritional counseling sessions rendered by a Physician or duly certified, registered or licensed health care profession with expertise in diabetes management once a patient is diagnosed with diabetes.

Diagnostic Services - X-ray, other imaging and laboratory examinations made for Medically Necessary diagnostic or Treatment purposes.

Electroconvulsive Therapy

Emergency Accident Care and Emergency Medical Care – Services that are provided for the initial outpatient treatment, including related Diagnostic Services, of accidental injuries or the sudden and unexpected onset of a medical condition that the absence of immediate medical attention would likely result in serious and permanent medical consequences.

Examples of emergency medical conditions are: severe chest pains, convulsions or persistent severe abdominal pains.

Facility benefits for an Inpatient or Outpatient care resulting from an Emergency Accident or Medical Emergency will be provided at the same payment level that you would have received had you received care in a Network Facility, regardless of whether care is received in a Network Facility, or an Out-of-Network Facility Provider.

Services received from an Out-of-Network Professional Provider for an Emergency Accident or Medical Emergency will be provided at the same payment level that you would have received had you received care from a Network Specialist or Network PCP based on whether the Provider is a Specialist or a Primary Care Physician.

For Inpatient Hospital stays, this provision only applies for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator to be serious and therefore not permitting your safe transfer to a Network Facility. Benefits for an Inpatient Hospital admission resulting from an Emergency Accident or Medical Emergency will be provided at the Plan's standard payment level for that portion of your Inpatient Hospital stay during which your condition is reasonably determined by the Claim Administrator as not being serious and therefore permitting your safe transfer to a Network Facility or permitting use of a Network Specialist or Network PCP.

For care to be considered Emergency Accident Care, Treatment must occur within 72 hours of the accident or as soon as reasonably possible.

Plan payments for Emergency Accident or Emergency Medical Care provided by an Out-of-Network Provider will be based on the Eligible Charge. You are responsible for the difference, if any, between the Eligible Charge and the amount the provider bills, in addition to the Deductible and Coinsurance that applies to the services you receive.

Covered Services received for Emergency Accident Care or Emergency Medical Care resulting from criminal sexual assault or abuse will be paid at 100% of the Eligible Charge whether or not you have met your annual Medical Deductible.

Extended Care Facility Services. - see Skilled Nursing Facility Care.

Foot Care – Preventive foot care examinations and trimming of corns, calluses, or toenails by a Physician or podiatrist are covered for Covered Persons who have been diagnosed with diabetes. Medically Necessary foot care by a Physician or podiatrist is covered for all Covered Persons.

Hearing (or Audiology). One routine hearing screening is covered per Benefit Period for each Covered Person under the ***Wellness and Preventive Care*** provisions of the Plan. Additionally, Medically Necessary hearing testing and Treatment are covered.

Hospice Care. For a Covered Person whose attending Physician has certified is terminally ill with a life expectancy of one year or less who has chosen Hospice Care services in lieu of standard services, Benefits are paid for charges incurred as a result of:

- Coordinated Home Care;
- Medical supplies and dressings;
- Prescription Drugs;
- Nursing services - skilled and non–skilled;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Inpatient Hospice room and board (up to the facility's most common semi-private rate);
- Social and spiritual services; and
- Respite Care Service.

The following services are **not** covered under the Hospice Care benefit:

- Durable Medical Equipment;
- Home delivered meals;

- Homemaker services;
- Traditional medical services provided for the direct care of the terminal illness, disease or condition;

Transportation, including, but not limited to, Ambulance services. Notwithstanding the above, there may be clinical situations when short episodes of traditional care would be appropriate even when the patient remains in Hospice Care. While these traditional services are not eligible under this Hospice Care benefit, they may be covered under another section of this SPD.

Human Papillomavirus Vaccine – The human papillomavirus (HPV) vaccine approved by the federal Food and Drug Administration will be covered pursuant to the terms in the ***Wellness and Preventive Care*** section.

Immunizations - The Plan pays 100% of Eligible Charges with no deductible requirement and no calendar year maximum for immunizations outlined in the ***Wellness and Preventive Care*** section. Vaccinations and inoculations solely required for travel or recreational purposes are not covered.

Infertility Testing - Covered Expenses are limited to Eligible Charges for x-ray and laboratory examinations performed solely for the purpose of diagnosing infertility. Benefits will not be provided for the Treatment of infertility.

Inpatient Hospital Care – Eligible Charges for the following are Covered Expenses when you receive them as an Inpatient in a Hospital.

- Bed, board, general nursing care, meals and dietary services provided by the Hospital. All semi-private room, ward accommodations and intensive care unit rooms are covered. For private rooms, an allowance will be paid equal to the Hospital's most common semi-private room charge. If the Hospital has only private rooms, those charges will be considered semi-private. If a private room is Medically Necessary, and ordered by a Physician, the private room charge will be covered.
- Ancillary services (such as operating rooms, drugs, surgical dressings and lab work) See the ***Utilization Management*** section.

Intensive Care and Coronary Care Units - All Medically Necessary charges are covered.

Mammography - Eligible Charges for mammograms will be considered Covered Expenses under the Plan's ***Wellness and Preventive Care*** benefits.

Mastectomy–Related Services - Benefits for Covered Expenses related to mastectomies are the same as for any other condition. Mastectomy–related Covered Expenses include, but are not limited to Eligible Charges for:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance;
- Inpatient care following a mastectomy for the length of time Medically Necessary and in accordance with protocols and guidelines based on sound scientific evidence and patient evaluation and a follow–up Physician office visit or in–home nurse visit within 48 hours after discharge; and
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to, lymphedemas.

Maternity and maternity related illnesses are covered in the same manner as any other illness.

Benefits will be paid for services received in connection with both normal pregnancy and

complications of pregnancy. As part of your maternity benefits certain services rendered to your newborn infant may be covered. These Covered Services are: a) the routine Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery. The Medical Deductible does not apply for services rendered to the newborn infant.

Newborn physician and Hospital charges will be covered for the first 30 days if you are covered at the time of the child's birth. Unless you enroll the child in coverage within 30 days after the child's birth, the child will no longer be covered.

Benefits will be provided for any Hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery or no less than 96 hours following a cesarean section. Your Provider is requested to provide notification to the Claim Administrator for all childbirth deliveries, to assist when Prior Authorization is needed when a stay is needed longer than 48 hours following a vaginal delivery and 96 hours following cesarean section.

Medical Supplies and Medical Equipment

a. Surgical dressings, supplies, casts, splints, trusses, and crutches.
b. Oxygen and rental of equipment for its administration.
c. Rental (up to the purchase price) or at the Member's option (if less expensive), the purchase of Durable Medical Equipment required for therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. Examples of Durable Medical Equipment include wheelchairs, Hospital beds, iron lung or other respiratory paralysis equipment, and kidney dialysis equipment.
d. Prosthetic devices, special appliances, and surgical implants when:
   - Required to replace all or part of an organ or tissue of the human body, or
   - Required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

   Benefits include adjustments, repair and replacements of covered prosthetics devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the Treatment of Temporomandibular Dysfunction and related disorders, subject to specific limitations applicable to Temporomandibular Dysfunction and related disorders, and replacement of cataract lenses when a prescription change is not required).
e. Insulin pump and insulin pump supplies.
f. First pair of frames and lenses or contact lenses following cataract surgery with a letter of Medical Necessity or if a cataract surgery claim is on file with the Claims Administrator.
g. Leg, arm, back, and neck braces only if required because of Injury or Sickness.
h. Internal cardiac valves, pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices.
i. Wigs when your hair loss is due to chemotherapy, radiation therapy, or alopecia. Benefits for wigs are limited to one per calendar year.

Mental Illness Services - Benefits for all of the Covered Expenses described in this SPD are available for the diagnosis and/or Treatment of a Mental Illness.

Miscellaneous Hospital Services including equipment, medications and supplies provided in conjunction with an Inpatient Hospital admission or an Outpatient Surgery.

Morbid Obesity - Treatment of morbid obesity, including Physician's services, laboratory fees, and Nutritional Counseling Services by a registered dietician (RD), but excluding special foods, programs, or plans.

Professional Provider services for weight-loss Surgery for carefully selected patients with Morbid Obesity is covered when less invasive methods of weight loss have failed and the patient is at high-risk for obesity-associated mortality and morbidity. To be eligible for coverage of weight-loss surgery, all of the following requirements must be met:

1. The Plan Member must meet the requirements specified in the Morbid Obesity definition.
2. The Plan Member must have tried multiple diets at least 12 months before considering surgery, and have devised a diet history substantiating unsuccessful attempts at sustainable weight loss.
3. The Plan Member must undergo a preoperative mental health visit to be screened for psychological disorders, to assess eating patterns and to determine if he/she has the coping skills and support systems necessary to do well with surgery. The results of this evaluation must indicate that weight-loss surgery is appropriate for the Plan Member.

Benefits will be provided for transportation and lodging for the patient and a companion. For transportation and lodging benefits to be available, your place of residency must be more than 50 miles from the HSHS Facility where the weight loss surgery will be performed.

- The patient and their companion are each entitled to benefits for lodging up to a separate maximum of $50 per day.
- Benefits for transportation and lodging are limited to a combined lifetime maximum of $5,000.
- Travel time and related expenses required by a Provider will not be covered.

Covered transportation and lodging expenses related to weight loss surgery at an HSHS Facility should be submitted to the HSHS Colleague Service Center. The HSHS Colleague Service Center will forward the expenses to Dean Health Plan for processing.

Facility expenses for weight loss surgery are only covered if the surgery is performed at an HSHS Facility.

The following are not covered:

- Surgical management of obese individuals that do not meet the Plan's coverage criteria.
- Weight loss drugs regardless of whether a Prescription Drug or over-the-counter drug.
- Facility charges for weight-loss Surgery if not performed at an HSHS Facility.
- When Medically Necessary, repeat surgical procedures for the Treatment of Morbid Obesity are covered when ALL of the following criteria are met:
  - The Covered Person met all of the requirements of this Plan at the time the original surgery was performed,
  - The Covered Person has been compliant with a prescribed nutrition and exercise program following the original surgery, AND
  - Significant complications or technical failure (e.g., break down of gastric pouch, slippage, breakage or erosion of gastric band, bowel obstruction, staple line failure, etc.) of the bariatric surgery has occurred that requires take down or revision of the

original procedure that could only be addressed surgically, AND

- The bariatric surgical modality meets generally accepted clinical guidelines.

A Roux-en-Y procedure following a previously approved vertical banded gastroplasty or laparoscopic adjustable banded gastroplasty is ***not eligible*** for coverage for Covered Persons who have been substantially noncompliant with a prescribed nutrition and exercise program following the original procedure.

Newborn Services are: a) the Inpatient Hospital nursery charges and b) one routine Inpatient examination and c) one Inpatient hearing screening as long as this examination is rendered by a Physician other than the Physician who delivered the child or administered anesthesia during delivery.

If a newborn child is an eligible covered Dependent on the date of birth and requires Treatment for an illness or Injury, a separate Coinsurance will apply.

Nurse Practitioner and Physician Assistant Services for medical care and Treatment, provided the services are within the scope of the Provider's professional license and are otherwise covered by the Plan. Services provided by a Nurse Practitioner or Physician Assistant that are submitted by a Primary Care Physician practice will be subject to the plan provisions applicable to PCPs. Services provided by a Nurse Practitioner or Physician Assistant that are submitted by a Specialist Physician practice will be subject to the plan provisions applicable to Specialist Physicians.

Nutritional Counseling Services - Services provided by a registered dietician (RD) to assess current nutritional status and to provide education on health nutrition to promote a healthy lifestyle and/or reduce or alleviate the effects of Sickness when Medically Necessary.

Occupational Therapy to restore a physical function when rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before Treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Organ Transplants - Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for cornea, kidney, bone marrow, heart valve, muscular–skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows: If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this SPD will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

- If you are the donor for the transplant and no coverage is available to you from any other source, the benefits described in this SPD will be provided for you. However, no Plan benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient services related to the transplant Surgery;
- the evaluation, preparation and delivery of the donor organ;
- the removal of the organ from the donor; and
- the transportation of the donor organ to the location of the transplant Surgery.

Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for transplants will be provided as follows:

- When a transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before you schedule a consultation with a transplant surgeon. The Claim Administrator will furnish you with the names of transplant Centers of Excellence which have Claim Administrator approved Transplant Programs. No benefits will be provided for any transplants performed at any Hospital that does not have a Claim Administrator approved Center of Excellence Transplant Program.
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a covered dependent child under age 19, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For transportation and lodging benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
  - You and your companion are each entitled to benefits for lodging up to a separate maximum of $50 per day.
  - Benefits for transportation and lodging are limited to a combined lifetime maximum of $5,000.

In addition to the other exclusions of this Plan, benefits will **not** be provided for the following:

- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery.
- Travel time and related expenses required by a Provider.
- Drugs which do not have approval of the Food and Drug Administration.
- Storage fees.
- Services provided to any individual who is not the recipient or actual donor, unless otherwise specified in this section.

Orthotics with adequate evidence of Medical Necessity and/or therapeutic value.

Oxygen and its administration**.**

Pap Smear Test – A Pap smear test will be considered a Covered Service under the Plan's ***Wellness and Preventive Care*** benefit.

Partial Hospitalization Treatment - Benefits are available for a Partial Hospitalization Treatment Program which has been approved by the Claim Administrator.

Physician Consultations – Consultations requested by your Physician of another Physician in the diagnosis or Treatment of a condition that requires special skill or knowledge. However, Benefits are not provided for a consultation done because of Hospital regulations or by a Physician who also renders Surgery or maternity services during the same Hospital Inpatient admission.

Physician Visits – including:

- when you visit your Physician's office or your Physician comes to your home to treat a medical condition;
- Physician visits when you are an Inpatient in a Hospital, a Skilled Nursing Facility, or Substance Abuse Treatment Facility; and

- Physician visits when you are a patient in a Partial Hospitalization Treatment program or Coordinated Home Care.

Physical Therapy provided by a Licensed Physical Therapist or a Physical Therapy aide under the direction of a Licensed Physical Therapist according to a written plan established in conjunction with the Covered Person's Physician and regularly reviewed by the therapist and the Physician. The plan must be established before Treatment is begun and must relate to the type, amount, frequency and duration of therapy and indicate the diagnosis and anticipated goals.

Physician's or Surgeon's Services for medical care and Treatment.

Preadmission Testing - Benefits are provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided that benefits would have been available to you had you received these tests as an Inpatient in a Hospital. Benefits will not be provided if you cancel or postpone the Surgery. These tests are considered part of your Inpatient Hospital surgical stay.

Prescription Drug Benefits - When you are being treated for an illness or Injury, your Physician, Nurse Practitioner or Physician Assistant may prescribe certain medications as part of your Treatment. The Prescription Drug benefits of the Plan provide coverage for Prescription Drugs that are self-administered and associated supplies. Benefits will only be provided if such Prescription Drugs and supplies are Medically Necessary.

The term Covered Prescription Drugs means:

- self-administered Prescription Legend Drugs for which a written prescription is required, including Prescription Legend Drugs for smoking cessation;
- a compound self-administered medication of which at least one ingredient is a Prescription Legend Drug;
- vitamins, including prenatal vitamins, which require a written prescription;
- oral or self-injectable insulin dispensed only upon the written prescription of a Physician;
- insulin needles and syringes;
- diabetic supplies, as follows: glucose test strips, lancets, glucagon emergency kits, and glucometers.

Prescription Drug benefits will ***not*** be provided for:

- birth control drugs or devices, whether or not dispensed by prescription, which are purchased or prescribed for the sole purpose of preventing conception;
- drugs used for cosmetic purposes (including, but not limited to, Retin–A/Tretinoin and Minoxidil/Rogaine);
- drugs used for the Treatment of infertility;
- drugs for which there is an over–the–counter product available with the same active ingredient(s);
- drugs which are not self–administered;
- medicinal marijuana;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

In addition, benefits will not be provided for any refills if the prescription is more than one year old.

Please see the Prescription Drug section of the ***Summary Schedule of Benefits*** for other limitations and provisions that apply.

Private Duty Nursing Service - Benefits for Private Duty Nursing Service will be provided to you in your home only when the services are of such a nature that they cannot be provided by non–professional personnel and can only be provided by a licensed health care provider. Private Duty Nursing includes teaching and monitoring of complex care skills such as tracheotomy suctioning, medical equipment use and monitoring to home caregivers and is not intended to provide for long term supportive care. Benefits for Private Duty Nursing Service will not be provided due to the lack of willing or available non–professional personnel.

Prostate Test and Digital Rectal Examination – Routine prostate specific antigen (PSA) tests and digital rectal examinations will be covered pursuant to the terms in the ***Wellness and Preventive Care*** section.

Radiation Therapy by x-ray, radon, radium and radioactive isotopes.

Renal Dialysis Treatments if received in a Hospital, a Dialysis Facility or in your home under the supervision of a Hospital or Dialysis Facility.

Residential Treatment Center Services that are not Custodial Services.

Shingles Vaccine – The shingles (Zoster) vaccine approved by the federal Food and Drug Administration will be covered pursuant to the terms in the ***Wellness and Preventive Care*** section.

Skilled Nursing Facility Care - Room, board, general nursing services, and ancillary services (such as drugs and surgical dressings and supplies) for a maximum of 90 days per confinement, renewable after 180 days between discharge and re-admission. Benefits will not be provided for Covered Services received in a Skilled Nursing Facility that has not been certified in accordance with Medicare's guidelines.

No benefits will be provided for admissions to a Skilled Nursing Facility that are for the convenience of the patient or the Physician or because care in the home is not available or the home is unsuitable for such care.

Speech Therapy, by a Speech Language Pathologist, certified by the American Speech and Hearing Association, to restore speech loss, or correct an impairment, due to (a) a congenital defect, or (b) an Injury or Sickness except a mental, psychoneurotic, or personality disorder. Inpatient Speech Therapy benefits will be provided only if Speech Therapy is not the only reason for admission.

Spinal Manipulation – Covered Expenses for a Physician to perform, on an Outpatient basis, manipulative treatment or other physical treatment for conditions caused by biomechanical or nerve conduction disorders of the spine. Up to 10 visits in a calendar year are covered under the plan.

Substance Abuse Rehabilitation Treatment - Benefits for all of the Covered Expenses described in this SPD are available for the diagnosis and/or Treatment of substance abuse. Additionally, benefits will be provided as if these services are rendered by a Substance Abuse Treatment Facility.

Surgery - Benefits are available for Surgery performed by a Physician, dentist or podiatrist. However, for services performed by a dentist or podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable

under this Plan had they been performed by a Physician. Only those oral surgery procedures specified in Dental Treatment or Service in this section are covered.

Services performed by a Physician, dentist or podiatrist who assists the operating surgeon in performing a covered Surgery in a Hospital or Ambulatory Surgical Facility are covered. In addition, benefits will be provided for assistance at Surgery when performed by a registered surgical assistant or an Advanced Practice Nurse. Benefits will also be provided for assistance at Surgery performed by a Physician Assistant under the direct supervision of a Physician, dentist or podiatrist.

Virtual Care when provided by the HSHS Medical Group. The HSHS Healthy Plan does not cover Virtual Care from other providers.

You can visit with a doctor or nurse with the HSHS Medical Group by webcam or telephone – 24 hours, 7 days a week. Virtual Care is available online at anytimecare.com, or you can call 844-391-4747 and speak with a provider.

Well Child Care. The Plan pays for 100% of well child care charges with no deductible as specified in the ***Wellness and Preventive Care*** section.

COORDINATION OF BENEFITS

Because the sole purpose of health care coverage is to help meet actual medical expenses, nearly all group health plans contain a "coordination of benefits" requirement. Coordination of benefits applies to any situation in which a Covered Person is also enrolled in any other plan of health benefits. It means that a Member covered under this Plan and any other plan of health benefits will be reimbursed up to 100% of his/her Covered Expenses. However, under no circumstances will the total benefits paid by this Plan, in conjunction with the benefits of another plan that is "primary" exceed 100% of Covered Expenses.

Simply stated, coordination of benefits works like this: If you are covered by more than one plan of group health benefits, one of the plans is considered to be "primary" and pays for your Covered Expenses up to the limits of its benefits. The other plans are considered "secondary," and pay any remaining Covered Expenses you may have, up to the limits of their benefits.

It is your responsibility to notify the Claim Administrator of any other group health benefit coverages in which you and/or your Dependents covered under this Plan are enrolled.

Coordination of Benefits does not apply to this Plan's Outpatient Prescription Drug benefits.

BENEFIT DETERMINATION RULES

The rules below establish the order in which benefits will be determined:

1. The benefits of a plan which covers the person for whom a claim is made other than as a dependent will be determined before a plan which covers that person as a dependent. In other words, that plan is primary and the other coverage is secondary.
2. When a dependent child receives services, the birthdays of the child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) occurs first in a calendar year will be considered primary. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. However: (a)) if the other plan does not have this rule, its alternative rule will govern; and (b) in the case of a dependent child of divorced or separated parents, the rules in item (3) will apply.
3. If there is a court decree which establishes financial responsibility for medical, dental or other health care of the child, the benefits of the plan which covers the child as a dependent of the parent so responsible will be determined before any other plan. Otherwise:
    a. The benefit of a plan which covers the child as a dependent of the parent with custody will be determined before a plan which covers the child as a dependent of a stepparent or a parent without custody.
    b. The benefits of a plan which covers the child as a dependent of a stepparent married to the parent with custody will be determined before a plan which covers the child as a dependent of the parent without custody.
4. When the above rules do not establish the order, the benefits of a plan which has covered the person for whom a claim is made for the longer period of time will be determined before a plan which has covered the person for the shorter period of time; except that:
    a. The benefits of a plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

b. If the other plan does not have the rule in item (4) (a), which results in each plan determining its benefit after the other, then item (4) (a) will not apply.

The only time these rules will not apply is if the other group health benefit plan does not include a coordination of benefits (COB) provision. In that case, the other plan is automatically primary. Additionally, special provisions apply in determining if this Plan or Medicare is primary. If you or a dependent covered by this Plan are eligible for Medicare, please review the ***Medicare Secondary Payer Laws*** and ***Benefits For Medicare Eligible Covered Persons not Subject to MSP Laws*** sections that follow the example.

The following example shows how this Plan will pay if it is secondary (determines its benefits after another group health plan).

Secondary Payment Example (assumes deductibles have been met)	
A. Amount Billed	$1,200
B. Less Discount (if any)	- 200
C. Allowable Charges under this Plan (A-B)	$1,000
D. Amount Primary Plan Paid	$ 720
E. Allowable Charges Remaining after Primary Plan Payment (C-D)	**$ 280**
F. This Plan's Benefit, absent coverage under Primary Plan	**$ 800**
This Plan pays the difference between the Allowable Charges (C) and the amount paid by the Primary Plan (D), but not more than this Plan's Benefit absent Primary Plan coverage (F). In other words, the lesser of this Plan's Benefit absent Primary Plan coverage (F) and the Allowable Charges Remaining after deducting the Primary Plan's Payment (E).	**$ 280**

MEDICARE SECONDARY PAYER LAWS

A series of federal laws collectively referred to as the ''Medicare Secondary Payer'' (MSP) laws regulate the manner in which employers may offer group health care coverage to Medicare eligible employees, spouses, and in some cases, dependent children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and employer group health plan ("GHP") coverage, as well as certain other factors. In general, Medicare pays secondary to the following:

1. GHPs that cover individuals with end–stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of the number of employees employed by the employer or whether the individual has "current employment status."

   In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status."

2. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status."

Your MSP Responsibilities

In order to assist the Plan in complying with MSP laws, it is very important that you promptly and accurately complete any requests for information from the Claim Administrator and/or your employer regarding the Medicare eligibility of you, your covered spouse or covered dependent children. In addition, if you, your covered spouse or covered dependent child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please contact your HSHS Colleague Service Center promptly to ensure that your Claims are processed in accordance with applicable MSP laws.

Benefits For Medicare Eligible Covered Persons not Subject to MSP Laws

The benefits and provisions described throughout this SPD apply to Medicare eligible Covered Persons who are not affected by MSP laws. However, in determining the benefits to be paid for Covered Expenses, consideration is given to the benefits available under Medicare as follows:

1. determine what the payment for a Covered Expense would be following the payment provisions of this Plan
2. deduct from the charges eligible under Medicare, the amount paid by Medicare
3. the lesser of the two amounts determined in accordance with step 1 and step 2 above is the amount that will be paid under this Plan.

When you have a Claim, you must send the Claim Administrator a copy of your Explanation of Medicare Benefits ("EOMB") in order for your Claim to be processed. In the event you are eligible for Medicare but have not enrolled in Medicare, the amount that would have been available from Medicare, had you enrolled, will be used.

COORDINATION WITH THE HSHS DENTAL PLAN

In the event you (and your covered Dependents) have both health and dental insurance coverage, through HSHS, expenses for the extraction or excision of impacted teeth are covered first under the HSHS Healthy Plan.

Please request that your Provider submit Claims for these services to DHP Health Plan Administrative Services.

Once your Claim for extraction or excision of impacted teeth has been processed by DHP Health Plan Administrative Services, you may then submit any expenses not paid by the HSHS Healthy Plan to the dental plan for consideration.

EXCLUSIONS AND LIMITATIONS

NO PAYMENT FOR PROFESSIONAL, FACILITY, OR OTHER CHARGES SHALL BE MADE UNDER THIS PLAN FOR:

- Abortions, sterilizations, elective sterilization reversal, sexual reassignment, in-vitro fertilization, artificial insemination, or embryonic implantation procedures.
- Any expenses where there is no legal obligation or financial liability to pay or would have no legal obligation to pay if you did not have this coverage. If a Provider limits charges to those paid by this Plan, those charges are not covered by this Plan.
- Any Treatment or service which is covered by no-fault (automobile) state provisions or other similar legislation.
- Any Treatment or service not prescribed by a medical professional operating within the scope of their license in the state in which services are received.
- Any Treatment or service provided by a member of the immediate family (Member, spouse, child, brother, sister, or parent of the Member or Member's spouse).
- Any Treatment, confinement, services, or supplies if the expense is incurred by a patient covered under an HMO provided by the patient's employer.
- Any Treatment or service which is compensated for or furnished by the Federal, state, or local governments, whether or not payments or benefits are received. This exclusion shall not apply to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5–1 et seq. or 5/6–1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Any Treatment or service resulting from Sickness which is covered by a Worker's Compensation Act or other similar legislation; or due to Injury incurred as the result of, or in the course of, any employment for wage or profit including self-employment.
- Any Treatment or service provided by an Out-of-Network Provider without Prior Authorization from the Claim Administrator.
- Birth control drugs, devices, injections, or implants whether or not dispensed by Prescription, purchased or prescribed for the sole purpose of preventing conception.
- Blood derivatives which are not classified as drugs in the official formularies.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Complications resulting from an excluded service, except for complications resulting from a health care service, supply or drug that is the subject of a clinical trial.
- Cosmetic Prescription Drugs.
- Cosmetic surgery and related services and supplies, including Prescription Drugs, except for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases.
- Procurement or use of prosthetic devices, special equipment and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the Treatment of disease or Injury.

- Expenses for Injuries sustained while committing or attempting to commit a criminal act:
  - involving the illegal use of drugs or alcohol, including but not limited to driving while under the influence of an illegal substance or alcohol as defined by the state in which the offense took place; or
  - involving violence or the threat of violence to another person; or
  - in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Person.
- Any Treatment or service for Sickness or Injury resulting from participation in a riot, insurrection, or in the commission of an assault or felony.
- Custodial Care.
- Day care.
- Recreational care.
- Vocational training.
- Dental Treatment or service, except as specified in Covered Services.
- Diagnostic testing that is part of a survey or research study or that is Investigational.
- Education or training.
- Experimental and/or Investigational Services and Supplies.
- Routine foot care, including trimming of corns, calluses, or toenails, except for persons diagnosed with diabetes.
- Any charges which exceed Eligible Charges.
- Services or supplies received from an employee health clinic or a similar person or group.
- Glasses (frames and lenses) and contact lenses (except for Treatment of cataracts), eye examinations or Treatment of a refractive error for the correction of vision or fitting of glasses, laser eye (Lasik) surgery, orthoptics, visual training, or vision therapy.
- Hearing aids and examinations for the prescription or fitting of hearing aids.
- Heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Center of Excellence Transplant Program.
- The following Home Health Care Agency services:
  - Food, food supplements (except for sustaining life), home delivered meals;
  - Transportation expenses;
  - Nursing care except as specified in the Covered Services section (page 41);
  - Maintenance Therapy;
  - Custodial Care;
  - Housekeeping services.

Hospitalization when it is not Medically Necessary. A hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition. Examples of hospitalization

services that are not Medically Necessary include:

- Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
- Hospital admissions primarily for diagnostic studies (x–ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.
- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

The fact that your Physician may prescribe, order, recommend, approve or view hospitalization or other health care services and supplies as Medically Necessary does not make the hospitalization, services or supplies Medically Necessary and does not mean that the Plan will pay the cost of the hospitalization, services or supplies.

- Inpatient Private Duty Nursing Services.
- Long Term Care Services.
- Maintenance Care.
- Maintenance Therapy except as specifically provided in the Covered Services section.
- Marriage counseling.
- Maternity care related to a Covered Person serving in the capacity of a surrogate mother.
- Any Treatment, service, device or supply solely to increase height or alter rate of growth.
- Any Treatment, service, or supply that is not Medically Necessary or does not meet accepted standards of medical practice.
- Personal hygiene, comfort, or convenience items such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Private Duty Nursing Services during a period in which the individual is receiving Home Health Care Agency services.
- Respite Care Services, except as specifically provided for Hospice Care.
- Services and supplies received prior to your Coverage Date.
- Services and supplies received after your coverage termination date.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This exclusion does not apply to services or supplies provided for the Treatment of an Injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Speech Therapy when rendered for the Treatment of psychosocial speech delay, behavioral problems (including impulsive and impulsivity syndrome) , attention disorder, conceptual handicap or mental disability with the exception of covered ABA

therapy for autism spectrum disorders.

- Any non-surgical Treatment of temporomandibular joint syndrome (TMJ).
- Travel, other than transportation by designated emergency vehicle, unless otherwise specified, whether or not recommended by a Physician.
- Any treatment or service received outside of the USA other than care to treat a Medical Emergency or Emergency Accident and care required to treat an unexpected episode of illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care.
- Any Treatment or service resulting from war or any act of war, declared or undeclared.
- Marijuana, even if medicinal and prescribed by a Physician.
- Whirlpools, portable whirlpools, sauna baths, and elevators.
- Treatment of impulse control disorders, such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Disposable outpatient supplies such as bags, elastic garments, bedpans, compresses and other devices not intended for reuse by another patient.
- Alternative/complementary medicine services will be excluded, including but not limited to: aromatherapy, bioenergetics therapy, carbon dioxide therapy, chelation therapy, hair analysis, hypnosis, megavitamin therapy, primal therapy, psychodrama, purging, rolfing, and thermogenic therapy.
- Expenses for any of the following services rendered as a Treatment for an Autism Spectrum Disorder:
  - Animal-based therapy including hippotherapy.
  - Auditory integration training.
  - Chelation therapy.
  - Child care fees.
  - Cost for the facility or location when treatment, therapy or services are provided outside a Member's home.
  - Cranial sacral therapy.
  - Custodial or respite care.
  - Hyperbaric oxygen therapy.
  - Provider travel expenses.
  - Special diets and supplements.
  - Therapy, treatment or services to a Member residing in a residential treatment center, inpatient treatment or day treatment facility.
- Facility charges for services or supplies for weight reduction by surgical method including but not limited to, gastric bypass, gastric balloon, stomach stapling, jejunal bypass, wiring of the jaw or any services of similar nature that are not performed at an HSHS Facility. Also excluded are:
  - any charges for special foods related to weight reduction or weight control, and
  - special programs or plans for weight reduction or weight control, other than nutritional counseling services provided by a Registered Dietician (RD) under the

Wellness and Preventive Care benefit of this Plan or for the Treatment of Morbid Obesity.

If your Claim for benefits is denied on the basis that the services or supplies were not Medically Necessary, and you disagree with the Claim Administrator's decision, the Plan provides for an appeal of that decision. See the ***Claim Filing and Appeals Procedures*** section.

TERMINATION OF COVERAGE

Your coverage under this Plan and the coverage of all of your enrolled Dependents will end on the earliest of the following:

- On the date this Plan is discontinued;
- On the date you are no longer eligible for coverage under this Plan;
- On the date you begin active duty in the Armed Forces of any country, however, you can continue coverage under the provisions outlined under ***Uniformed Services Employment and Reemployment Rights Act of 1994*** that appears later in this section;
- On the date ending the period for which contributions, if required, have been paid.

In addition, coverage for your spouse or dependent child ends on the earliest of the following:

- The date your spouse no longer meets the requirements specified in ***Dependent Eligibility***
- For your dependent child, the end of the month in which the child no longer meets the requirements specified in ***Dependent Eligibility***

For coverage purposes, your employment is considered ended on the last day of the pay period in which you cease active work for the Employer.

If a spouse or dependent child that you have enrolled in the Plan ceases to meet the eligibility requirements of the Plan, it is your responsibility to notify the HSHS Colleague Service Center. You will be responsible for reimbursing the Plan for any expenses paid by the Plan for services incurred during periods that a dependent that you have enrolled in the Plan is not eligible to participate in the Plan.

No benefits are available to you for services or supplies rendered after the date of termination of your coverage under the HSHS Healthy Plan.

CONTINUATION OF COVERAGE

The following individuals who have been continuously covered under this Plan for three months may elect to continue group coverage under the Plan.

- A Colleague whose coverage would otherwise terminate (except those discharged for misconduct in connection with employment). The Colleague may also elect Continuation of Coverage for any Dependent covered under this Plan at the time of his/her coverage termination.
- The former spouse of a Colleague whose coverage would otherwise cease due to divorce or annulment.
- The spouse or Dependent child of a deceased Colleague.
- A Dependent child who reaches the limiting age.
- A child born to, or placed for adoption with, the covered Colleague during the period of continuation.

If you wish to continue coverage for yourself and/or your Dependents, you must notify your People Services Department within 30 days of the qualifying event. You may continue your group coverage for up to a maximum of 18 months or until age 65, whichever occurs first. Persons who qualify for Social Security Disability during the first 60 days of continuous coverage may continue for up to 29 months from that date.

Colleagues who retired between the ages of 55 and 64 on or before December 31, 2015 and began to receive his/her HSHS pension are eligible for the lesser of 36 months of continuation coverage or coverage to age 65. If a retired Colleague who meets the criteria in the preceding sentence attains the age of 65 during the 36-month continuation period, his/her Dependents may continue coverage for the balance of the 36-month period or until the Dependent reaches age 65, whichever occurs first.

Premiums must be paid totally by the Covered Person and the premium payment must be received by the beginning of each pay period.

TERMINATION OF CONTINUATION OF COVERAGE

The continuation coverage will terminate automatically on the earliest of the following:

1. The date ending the period for which any required contribution has been paid;
2. The date you or your Dependent becomes covered under another group health plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

Under the Uniform Services Employment and Reemployment Rights Act of 1994 (the "Act"), if you leave employment to serve in the uniformed services of the United States, you and your Dependents have the right to continue coverage under this Plan for up to 24 months, beginning on the date you are first absent from work.

The period of continued coverage will end on the earliest of these dates:

- The last day of the 24-month period.
- The day military leave ends, if you do not apply for/return to employment within the time frames specified in the Act.
- The day any contribution is due and unpaid.

During the first 30 days of military service protected by the Act, you will be charged your regular contribution for continued coverage. After the first 30 days of military service, you will be charged the total premium for continued coverage.

If you allow coverage to lapse during military leave, you may request that it be reinstated when you return to employment with HSHS, provided you return to employment within the time frames imposed by the Act. The waiting period generally will not apply to your reinstated coverage. The Plan is permitted to apply exclusions and waiting periods to any illness or Injury which was incurred or aggravated during the period of military service.

CLAIM FILING AND APPEALS PROCEDURES

FILING MEDICAL SERVICE CLAIMS

In order to obtain your benefits under this Plan, it is necessary for a Claim to be filed with the Claim Administrator. To file a Claim, usually all you will have to do is show your ID card to your Hospital or Physician (or other Provider). They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Claim Administrator.

Once the Claim Administrator receives your Claim, it will be processed and the benefit payment will usually be sent directly to the Hospital or Physician. You will receive a statement telling you how your benefits were calculated. In some cases the Claim Administrator will send the payment directly to you or if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

In certain situations, you will have to file your own Claims. This is primarily true when you are receiving services or supplies from Providers other than a Hospital or Physician. An example would be when you have had ambulance expenses. To file your own Claim, follow these instructions:

1. Complete a Claim Form. These are available from the Claim Administrator's web site (www.deancare.com/aso.com) or customer service at 888-895-1188.
2. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, the patient's name, the diagnosis, the date of service and a description of the service and the Claim Charge.
3. Mail the completed Claim Form with attachments
   to: DHP Administrative Services
   PO Box 99906
   Grapevine, Texas 76099-9706
4. In any case, Claims should be filed with the Claim Administrator within one year following the date your Covered Service was rendered. **Claims not filed within one year from the date a service is received will not be eligible for payment.**

If you have any questions about filing Claims, contact DHP customer service at 888-895-1188 or the HSHS Colleague Service Center at 855-394-4747 or fyi@hshs.org.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In certain situations, you will have to file your own Claims in order to obtain benefits for Outpatient Prescription Drugs. This is primarily true when you did not receive an identification card or the Pharmacy was unable to transmit. To do so, follow these instructions:

1. Complete a Prescription Drug Claim Form. These forms are available from the Navitus web site (www.navitus.com) or pharmacy customer service at 866-333-2757.
2. Attach copies of all Pharmacy receipts to be considered for benefits. These receipts must be itemized.

3. Mail the completed Claim Form with attachments to:
   Navitus Health Solutions
   PO Box 999
   Appleton, WI 54912-0999

In any case, Claims must be filed no later than one year after the date a service is received. **Claims not filed within one year from the date a service is received will not be eligible for payment**.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

Under this Plan, the Claim Administrator has the right to make any benefit payment either to you or directly to the Provider of the Covered Services. For example, the Claim Administrator may pay benefits to you if you receive Covered Services from an Out-of–Network Provider. The Claim Administrator is specifically authorized to determine to whom any benefit payment should be made.

Once Covered Services are rendered by a Provider, you have no right to request the Claim Administrator not to pay the Claim submitted by such Provider and no such request will be given effect. In addition, the Claim Administrator will have no liability to you or any other person because of its rejection of such request.

A Covered Person's Claim for benefits under this Plan is expressly non–assignable and non–transferable in whole or in part to any person or entity, including any Provider, at anytime before or after Covered Services are rendered to a Covered Person. Coverage under this Plan is expressly non–assignable and non–transferable and will be forfeited if you attempt to assign or transfer coverage or aid or attempt to aid any other person in fraudulently obtaining coverage. Any such assignment or transfer of a Claim for benefits or coverage shall be null and void.

INITIAL CLAIMS DETERMINATIONS AND APPEALS PROCESS

Initial Claims Determinations

The Claim Administrator will usually pay all Claims within 30 days of receipt of all information required to process a Claim. The Claim Administrator will usually notify you, your valid assignee or your authorized representative, when all information required to pay a Claim within 30 days of the Claim's receipt has not been received. (For information regarding assigning benefits, see ***Payment of Claims and Assignment of Benefits*** above.) If you fail to follow the procedures for filing a pre–service Claim (as defined below), you will be notified within 5 days (or within 24 hours in the case of a failure regarding an urgent care/expedited clinical Claim).
Notification may be oral unless the claimant requests written notification.

If A Claim Is Denied Or Not Paid In Full

If a Claim for benefits is denied in whole or in part, you will receive a notice from the Claim Administrator within the following time limits:

1. For non–urgent pre–service Claims, within 15 days after receipt of the Claim by the Claim Administrator. A "pre–service Claim" is any non–urgent request for benefits or for a determination, with respect to which the terms of the benefit plan condition receipt of the benefit on approval of the benefit in advance of obtaining medical care.

2. For post–service Claims, within 30 days after receipt of the Claim by the Claim Administrator.

If the Claim Administrator determines that special circumstances require an extension of time for processing the Claim, for non–urgent pre–service and post–service Claims, the Claim Administrator shall notify you or your authorized representative in writing of the need for extension, the reason for the extension, and the expected date of decision within the initial period. In no event shall such extension exceed 15 days from the end of such initial period. If an extension is necessary because additional information is needed from you, the notice of extension shall also specifically describe the missing information, and you shall have at least 45 days from receipt of the notice within which to provide the requested information.

If the Claim for benefits is denied in whole or in part, you or your authorized representative shall be notified in writing of the following:

a. The reasons for denial;

b. A reference to the benefit plan provisions on which the denial is based;

c. A description of additional information which may be necessary to perfect an appeal and an explanation of why such material is necessary;

d. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), diagnosis, Treatment and denial codes with their meanings and the standards used;

e. An explanation of the Claim Administrator’s internal review/appeals and external review processes (and how to initiate a review/appeal or external review) and a statement of your right, if any, to bring a civil action following a final denial on internal review/appeal;

f. In certain situations, a statement in non–English language(s) that future notices of Claim denials and certain other benefit information may be available in such non– English language(s);

g. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;

h. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, and a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;

i. An explanation of the scientific or clinical judgment relied on in the determination as applied to claimant’s medical circumstances, if the denial was based on Medical Necessity, experimental Treatment or similar exclusion, or a statement that such explanation will be provided free of charge upon request;

j. In the case of a denial of an urgent care/expedited clinical Claim, a description of the expedited review procedure applicable to such Claims. An urgent care/expedited Claim decision may be provided orally, so long as written notice is furnished to the claimant with 3 days of oral notification;

k. Contact information for applicable office of health insurance consumer assistance or ombudsman.

3. For benefit determinations relating to urgent care/expedited clinical Claim (as defined below), notification to claimant of Claim determination will be made no later than 72

hours following receipt of your Claim for benefits. Notification of insufficient information on the Claim, will be provided no later than 24 hours after the receipt of your Claim for benefits. You will have no less than 48 hours to provide the information.

4. For benefit determinations relating to care that is being received at the same time as the determination, such notice will be provided no later than 24 hours after receipt of your Claim for benefits.

An "urgent care/expedited clinical Claim" is any pre–service Claim for benefits for medical care or Treatment with respect to which the application of regular time periods for making health Claim decisions could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or Treatment.

Inquiries and Complaints

An **"Inquiry"** is a general request for information regarding Claims, benefits, or membership.

A **"Complaint"** is an expression of dissatisfaction by you either orally or in writing.

The Claim Administrator has a team available to assist you with Inquiries and Complaints. Issues may include, but are not limited to Claims and quality of care.

When your Complaint relates to dissatisfaction with a Claim denial (or partial denial), then you have the right to a Claim review/appeal as described in the ***Claim Appeals*** section which follows.

To pursue an Inquiry or a Complaint, you may contact Customer Service at the number on the back of your ID card, or you may write to:

DHP Administrative Services
PO Box 1808
Grapevine, TX 76099-1808

When you contact Customer Service to pursue an Inquiry or Complaint, you will receive a written acknowledgement of your call or correspondence. You will receive a written response to your Inquiry or Complaint within 30 days of receipt by Customer Service. Sometimes the acknowledgement and the response will be combined. If the Claim Administrator needs more information, you will be contacted. If a response to your Inquiry or Complaint will be delayed due to the need for additional information, you will be contacted.

CLAIM APPEALS

An **"Appeal"** is an oral or written request for review of an Adverse Benefit Determination or an adverse action by the Claim Administrator, its employees or a participating provider.

An appeal of an Adverse Benefit Determination may be filed by you or a person authorized to act on your behalf. In some circumstances, a health care provider may appeal on his/her own behalf. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. To obtain an Authorized Representative Form, you or your representative may call the Claim Administrator at the number on the back of your ID card.

Claim Appeal Procedures - Definitions

An **"Adverse Benefit Determination"** means a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial,

reduction, termination, or failure to provide or make payment for, a benefit resulting from the application of utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be Experimental or Investigational or not Medically Necessary or appropriate. If an ongoing course of Treatment had been approved by the Claim Administrator or the Plan Sponsor and the Claim Administrator or your Plan Sponsor reduces or terminates such Treatment (other than by amendment or termination of this Plan) before the end of the approved Treatment period that is also an Adverse Benefit Determination. A rescission of coverage is also an Adverse Benefit Determination. A rescission does not include a termination of coverage for reasons related to non–payment of premium.

In addition, an Adverse Benefit Determination, also includes an "Adverse Determination." An **"Adverse Determination"** means a determination by the Claim Administrator or its designated utilization review organization that an admission, availability of care, continued stay, or other health care service that is a Covered Service has been reviewed and, based upon the information provided, does not meet the Claim Administrator's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness, and the requested service or payment for the service is therefore denied, reduced, or terminated. For purposes of this Plan, we will refer to both an Adverse Determination and an Adverse Benefit Determination as an Adverse Benefit Determination, unless indicated otherwise.

A **"Final Internal Adverse Benefit Determination"** means an Adverse Benefit Determination that has been upheld by the Claim Administrator or the Plan Sponsor at the completion of the Claim Administrator's or Plan Sponsor's internal review/appeal process.

Claim Appeal Procedures

If you have received an Adverse Benefit Determination, you may have your Claim reviewed on appeal. The Claim Administrator will review its decision in accordance with the following procedures. The following review procedures will also be used for Claim Administrator's (i) coverage determinations that are related to non–urgent care that you have not yet received if approval by your Plan is a condition of your opportunity to maximize your benefits and
(ii) coverage determinations that are related to care that you are receiving at the same time as the determination. Claim reviews are commonly referred to as "appeals."

Within 180 days after you receive notice of an Adverse Benefit Determination, you may call or write to the Claim Administrator to request a Claim review. The Claim Administrator will need to know the reasons why you do not agree with the Adverse Benefit Determination**. You may call 1–888-895-1188 or send your request to:**

Dean Health Plan Administrative Services
P.O. Box 1808
Grapevine, TX 76099-1808

In support of your Claim review, you have the option of presenting evidence and testimony to the Claim Administrator, by phone or in person at a location of the Claim Administrator's choice. You and your authorized representative may ask to review your file and any relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of an Adverse Benefit Determination or at any time during the Claim review process.

The Claim Administrator will provide you or your authorized representative with any new or additional evidence or rationale and any other information and documents used in the denial or the review of your Claim without regard to whether such information was considered in the initial determination. No deference will be given to the initial Adverse Benefit Determination. Such new or additional evidence or rationale and information will be provided to you or your authorized representative sufficiently in advance of the date a final decision on appeal is made in order to give you a chance to respond. The appeal will be conducted by individuals associated with the Claim Administrator and/or by external advisors who were not involved in making the initial denial of your Claim. Before you or your authorized representative may bring any action to recover benefits, the claimant must exhaust the appeal process and must raise all issues with respect to a Claim and must file an appeal or appeals and the appeals must be finally decided by the Claim Administrator or the Plan Sponsor.

Urgent Care/Expedited Clinical Appeals

If your appeal relates to an urgent care/expedited clinical Claim, or health care services, including but not limited to, procedures or Treatments ordered by a health care provider, the denial of which could significantly increase the risk to the claimant's health, then you may be entitled to an appeal on an expedited basis. Before authorization of benefits for an ongoing course of Treatment is terminated or reduced, the Claim Administrator will provide you with notice at least 24 hours before the previous benefits authorization ends and an opportunity to appeal. For the ongoing course of Treatment, coverage will continue during the appeal process. Upon receipt of an urgent care/expedited pre–service or concurrent clinical appeal, the Claim Administrator will notify the party filing the appeal, as soon as possible, but no more than 24 hours after submission of the appeal, of all the information needed to review the appeal. Additional information must be submitted within 24 hours of request. The Claim Administrator shall render a determination on the appeal within 24 hours after it receives the requested information.

Other Appeals

Upon receipt of a non–urgent pre–service or post–service appeal the Claim Administrator shall render a determination of the appeal within 30 days after the appeal has been received by the Claim Administrator or such other time as required or permitted by law.

If You Need Assistance

If you have any questions about the Claims procedures or the review procedure, write or call the Claim Administrator at 888-895-1188. The Claim Administrator offices are open from 7:30 AM to 5:00 PM Monday through Thursday and 8:00 AM to 4:30 PM Friday.

Dean Health Plan Administrative
Services PO Box 99906
Grapevine, TX 76099-9706

Notice of Appeal Determination

The Claim Administrator will notify the party filing the appeal, you, and, if a clinical appeal, any health care provider who recommended the services involved in the appeal, orally of its determination followed–up by a written notice of the determination.

The written notice will include:

1. The reasons for the determination;
2. A reference to the Plan provisions on which the determination is based, or the

contractual, administrative or protocol for the determination;

3. Subject to privacy laws and other restrictions, if any, the identification of the Claim, date of service, health care provider, Claim amount (if applicable), and information about how to obtain diagnosis, Treatment and denial codes with their meanings;
4. An explanation of the Claim Administrator's external review processes and how to initiate an external review;
5. In certain situations, a statement in non–English language(s) that future notices of Claim denials and certain other benefit information may be available in such non–English language(s);
6. The right to request, free of charge, reasonable access to and copies of all documents, records and other information relevant to the Claim for benefits;
7. Any internal rule, guideline, protocol or other similar criterion relied on in the determination, or a statement that a copy of such rule, guideline, protocol or other similar criterion will be provided free of charge on request;
8. An explanation of the scientific or clinical judgment relied on in the determination, or a statement that such explanation will be provided free of charge upon request;
9. A description of the standard that was used in denying the Claim and a discussion of the decision.

If the Claim Administrator's or the Plan Sponsor's decision is to continue to deny or partially deny your Claim or you do not receive a timely decision, you may be able to request an external review of your Claim by an independent third party, who will review the denial and issue a final decision.
Your external review rights are described in the ***Independent External Review*** section that follows. You must exercise the right to internal appeal as a precondition to taking any action against the Plan, either at law or in equity. If you have an adverse appeal determination, you may file civil action in a state or federal court.

INDEPENDENT EXTERNAL REVIEW

You or your authorized representative (as described above) may make a request for a standard external review or expedited external review of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination by an independent review organization (IRO).

External Review Procedures

1. **Request for external review**. Within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination from the Claim Administrator, you or your authorized representative must file your request for standard external review. If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

2. **Preliminary review**. Within 5 business days following the date of receipt of the external review request, the Claim Administrator must complete a preliminary review of the request to determine whether:
   a. You are, or were, covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
   b. The Adverse Benefit Determination or the Final Adverse Benefit Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   c. You have exhausted the Claim Administrator's internal appeal process unless you are not required to exhaust the internal appeals process. Please read the ***Exhaustion*** section that follows for additional information; and
   d. You or your authorized representative have provided all the information and forms required to process an external review.

   You will be notified within 1 business day after the Claims Administrator completes the preliminary review if your request is eligible or if further information or documents are needed. You will have the remainder of the 4–month appeal period (or 48 hours following receipt of the notice), whichever is later, to perfect the appeal request. If your Claim is not eligible for external review, the Claims Administrator will outline the reasons it is ineligible in the notice and provide contact information for the Department of Labor's Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

3. **Referral to Independent Review Organization**. When an eligible request for external review is completed within the time period allowed, the Claim Administrator will assign the matter to an independent review organization (IRO). The IRO assigned will be accredited by URAC or by similar nationally-recognized accrediting organization. Moreover, the Claim Administrator will take action against bias and to ensure independence. Accordingly, the Claim Administrator must contract with at least (3) IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent, unbiased methods for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

   The IRO must provide the following:
   a. Utilization of legal experts where appropriate to make coverage determinations under the plan.
   b. Timely notification to you or your authorized representative, in writing, of the request's eligibility and acceptance for external review. This notice will include a statement that you may submit in writing to the assigned IRO within ten business days following the date of receipt of the notice additional information that the IRO must consider when conducting the external review. The IRO is not required to, but may, accept and consider additional information submitted after 10 business days.
   c. Within 5 business days after the date of assignment of the IRO, the Claim Administrator must provide to the assigned IRO the documents and any information considered in making the Adverse Benefit Determination or Final

Internal Adverse Benefit Determination. Failure by the Claim Administrator to timely provide the documents and information must not delay the conduct of the external review. If the Claim Administrator fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the Adverse Benefit Determination or Final Internal Adverse Benefit Determination. Within 1 business day after making the decision, the IRO must notify the Claim Administrator and you or your authorized representative.

d. Upon receipt of any information submitted by you or your authorized representative, the assigned IRO must within 1 business day forward the information to the Claim Administrator. Upon receipt of any such information, the Claim Administrator may reconsider its Adverse Benefit Determination or Final Internal Adverse Benefit Determination that is the subject of the external review. Reconsideration by the Claim Administrator must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Claim Administrator decides, upon completion of its reconsideration, to reverse its Adverse Benefit Determination or Final Internal Adverse Benefit Determination and provide coverage or payment. Within 1 business day after making such a decision, the Claim Administrator must provide written notice of its decision to you and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Claim Administrator.

e. Review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the Claim de novo and not be bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process applicable under paragraph (b) of the interim final regulations under section 2719 of the Public Health Service (PHS) Act. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the following in reaching a decision:

   (1) Your medical records;

   (2) The attending health care professional's recommendation;

   (3) Reports from appropriate health care professionals and other documents submitted by the Claim Administrator, you, or your treating provider;

   (4) The terms of your Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law;

   (5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations;

   (6) Any applicable clinical review criteria developed and used by the Claim Administrator, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

   (7) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

f. Written notice of the final external review decision must be provided within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the Claim Administrator and you or your authorized representative.

g. The notice of final external review decision will contain:

  (1) A general description of the reason for the request for external review, including information sufficient to identify the Claim (including the date or dates of service, the health care provider, the Claim amount (if applicable), the diagnosis code and its corresponding meaning, the Treatment code and its corresponding meaning, and the reason for the previous denial);

  (2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision;

  (3) References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;

  (4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;

  (5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Claim Administrator and you or your authorized representative;

  (6) A statement that judicial review may be available to you or your authorized representative; and

  (7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under PHS Act section 2793.

h. After a final external review decision, the IRO must maintain records of all Claims and notices associated with the external review process for six years. An IRO must make such records available for examination by the Claim Administrator, State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws, and you or your authorized representative.

4. **Reversal of plan's decision.** Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Claim Administrator immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the Claim.

Expedited External Review

1. **Request for expedited external review.** The Claim Administrator must allow you or your authorized representative to make a request for an expedited external review with the Claim Administrator at the time you receive:

   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal under the interim final regulations would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Claim Administrator must determine whether the request meets the reviewability requirements set forth in the standard ***External Review Procedures*** above. The Claim Administrator must immediately send you a notice of its eligibility determination that meets the requirements set forth in the standard ***External Review Procedures*** above**.**
3. **Referral to independent review organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Claim Administrator will assign an IRO pursuant to the requirements set forth in the standard ***External Review Procedures*** above. The Claim Administrator must provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method.

   The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must review the Claim de novo and is not bound by any decisions or conclusions reached during the Claim Administrator's internal claims and appeals process.
4. **Notice of final external review decision.** The Claim Administrator's contract with the assigned IRO must require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth in the standard ***External Review Procedures*** above, as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 72 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the Claim Administrator and you or your authorized representative.

Exhaustion

For standard internal review, you have the right to request external review once the internal review process has been completed and you have received the Final Internal Adverse Benefit Determination. For expedited internal review, you may request external review simultaneously with the request for expedited internal review. The IRO will determine whether or not your request is appropriate for expedited external review or if the expedited internal review process must be completed before external review may be requested.

You will be deemed to have exhausted the internal review process and may request external review if the Claim Administrator waives the internal review process or the Claim Administrator has failed to comply with the internal claims and appeals process.

External review may not be requested for an Adverse Benefit Determination involving a claim for benefits for a health care service that you have already received until the internal review process has been exhausted.

GENERAL INFORMATION and NOTICES

RIGHT TO AMEND OR TERMINATE THE PLAN

Hospital Sisters Health System intends to continue this Plan indefinitely, but reserves the right to end or change the Plan at any time within the terms of the Plan document. Such changes may include changes in required contribution levels and adjustments to benefits. Expenses you incur before the date the Plan is terminated or amended will be paid according to the terms of the Plan before its termination or amendment.

RECOVERY OF OVERPAYMENTS

Occasionally, heath care benefits are paid more than once, are paid based on improper billing, or are not paid according to the Plan's terms, conditions, limitations, or exclusions. Whenever the Plan pays health care benefits exceeding the amount of the benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from the Covered Person on whose behalf such payment was made. This includes any payments made by the Plan for services incurred by dependents that you have enrolled in the Plan during periods that they are not eligible to participate in the Plan.

SUBROGATION

This Plan reserves all rights of subrogation. This means the Plan has the right to recover its previously paid benefit payments from any award, settlement, or damages that you or your covered Dependents may receive or become entitled to due to negligence of a third party. It also means that the Plan has the right to assert your rights (take action on your behalf) to obtain an award, settlement, or damages. The most common situations involving subrogation are auto accidents, but others include medical malpractice, accidental injuries, negligence, defective products, etc.

The Plan has the right to reimbursement for all benefits the Claim Administrator provided from any and all damages collected from the third party for those same expenses whether by action at law, settlement, or compromise, by you or your legal representative as a result of Sickness or Injury, in the amount of the total benefits the Plan paid to you or on your behalf. The Claim Administrator is assigned the right to recover from the third party, or his or her insurer, to the extent of the benefits the Plan provided for that Sickness or Injury.

The Claim Administrator shall have the right to first reimbursement out of all funds you, your covered Dependents or your legal representative, are or were able to obtain for the same expenses for which the Plan has provided benefits as a result of that Sickness or Injury.

You are required to furnish any information or assistance or provide any documents that the Claim Administrator may reasonably require in order to exercise the Plan's rights under this provision. This provision applies whether or not the third party admits liability.

RIGHT TO RECOVER BENEFIT PAYMENTS

The Plan shall have the first lien upon all awards, settlements, or damages subject to its subrogation or reimbursement rights. This lien shall be in the amount of benefits provided or the amount of benefits that will be provided under the Plan, plus the reasonable expenses, including attorney's fees to enforce the Plan's rights.

Conditions Precedent to Coverage. The Plan shall have no obligation whatsoever to pay medical or dental benefits to a Covered Person if a Covered Person refuses to cooperate with the Plan's reimbursement and subrogation rights or refuses to execute and deliver such papers as the Plan may require in furtherance of its reimbursement and subrogation rights. Further, in the event the Covered Person is a minor, the Plan shall have no obligation to pay any medical or dental benefits incurred on account of Injury or Sickness caused by a responsible third party until after the Covered Person or his authorized legal representative obtains valid court recognition and approval of the Plan's 100%, first dollar reimbursement and subrogation rights on all recoveries, as well as approval for the execution of any papers necessary for the enforcement thereof, as described herein.

Recovery from another plan under which the Covered Person is covered. This right of refund also applies when a Covered Person recovers under an uninsured or underinsured motorist plan or "no-fault" or automobile medical payment plan (all of which will be treated as third party coverage when reimbursement or subrogation is in order), homeowner's plan, renter's plan, medical malpractice plan or any liability plan.

YOUR PROVIDER RELATIONSHIPS

The choice of a Provider is solely your choice and neither the Plan nor the Claim Administrator will interfere with your relationship with any Provider.

The Claim Administrator does not itself undertake to furnish health care services, but solely to make payments to Providers for the Covered Services received by you. Neither the Claim Administrator nor the Plan are, in any event, liable for any act or omission of any Provider or the agent or employee of such Provider, including, but not limited to, the failure or refusal to render services to you. Professional services which can only be legally performed by a Provider are not provided by the Claim Administrator. Any contractual relationship between a Physician and a Network Provider shall not be construed to mean that the Claim Administrator is providing professional service.

The use of an adjective such as Network or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non–use or non–designation of Network, approved or any similar modifier or the use of a term such as Out-of-Network should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

NOTICES

Any information or notice which you furnish to the Claim Administrator under the Plan as described in this SPD must be in writing and sent to the Claim Administrator at its offices at PO Box 99906, Grapevine, Texas 76099 (unless another address has been stated in this SPD for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears on the Claim Administrator's records or in care of your Plan Sponsor and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

LIMITATIONS OF ACTIONS

No legal action may be brought to recover under the Plan as described in this SPD, prior to the expiration of sixty (60) days after a Claim has been furnished to the Claim Administrator in accordance with the requirements described in this SPD. In addition, no such action shall be brought after the expiration of three (3) years after the time a Claim is required to be furnished to the Claim Administrator in accordance with the requirements described in this SPD.

INFORMATION AND RECORDS

You agree that it is your responsibility to insure that any Provider, insurance company, employee benefit association, government body or program, any other person or entity, having knowledge of or records relating to (a) any illness or Injury for which a Claim or Claims for benefits are made under the Plan, (b) any medical history which might be pertinent to such illness, Injury, Claim or Claims, or (c) any benefits or indemnity on account of such illness or Injury or on account of any previous illness or Injury which may be pertinent to such Claim or Claims, furnish to the Claim Administrator or its agent, and agree that any such Provider, person or other entity may furnish to the Claim Administrator or its agent, at any time upon its request, any and all information and records (including copies of records) relating to such illness, Injury, Claim or Claims. In addition, the Claim Administrator may furnish similar information and records (or copies of records) to Providers, DHP Medical Management, insurance companies, governmental bodies or programs or other entities providing insurance–type benefits requesting the same. It is also your responsibility to furnish the Claim Administrator and/or the Plan Sponsor information regarding your or your dependents becoming eligible for Medicare, termination of Medicare eligibility or any changes in Medicare eligibility status in order that the Claim Administrator be able to make Claim Payments in accordance with MSP laws.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1988 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy has been performed,
- surgery and reconstruction of the other breast to produce a symmetrical appearance,
- prostheses, and
- Treatment of physical complications at any stage of the mastectomy including lymphedemas.

These items are covered by all of the health care options offered under this Plan. The health care option's normal benefit provisions will apply to these services.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

Group health plans generally may not, under federal law, restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending Provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans may not, under federal law, require that a Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT INFORMATION

Name of Plan:
The HSHS Healthy Plan

Health Plan Identifier (HPID): 7881697081

Plan Sponsor:
Hospital Sisters Health System

Name and Address of Plan Administrator:
Hospital Sisters Health System
P.O. Box 19456
Springfield, IL 62794-9456

PARTICIPATING EMPLOYERS:

- St. Elizabeth's Hospital
  Belleville, Illinois
- St. Joseph's Hospital
  Breese, Illinois
- St. Mary's Hospital
  Decatur, Illinois
- St. Anthony's Memorial Hospital
  Effingham, Illinois
- St. Joseph's Hospital
  Highland, Illinois
- St. Francis Hospital
  Litchfield, Illinois
- St. John's Hospital
  Springfield, Illinois
- Holy Family Hospital
  Greenville, Illinois
- St. Joseph's Hospital
  Chippewa Falls, Wisconsin
- Sacred Heart Hospital
  Eau Claire, Wisconsin
- St. Mary's Hospital Medical Center
  Green Bay, Wisconsin
- St. Vincent Hospital
  Green Bay, Wisconsin
- St. Clare Memorial Hospital
  Oconto Falls, Wisconsin
- St. Nicholas Hospital
  Sheboygan, Wisconsin
- HSHS Medical Group, Inc.
  Springfield, Illinois
- HSHS Wisconsin Medical Group, Inc.
  Springfield, Illinois
- Prairie Cardiovascular Consultants, Ltd.
  Springfield, Illinois
- Hospital Sisters Health System (HSHS)
  Springfield, Illinois
- Prairie Education & Research
  Cooperative
  Springfield, Illinois

APPENDIX A

PREVEA 360 NETWORK SERVICE AREA

If your primary home residence is in Eastern Wisconsin as defined by the zip code list below, your HSHS Healthy Plan coverage is administered by Dean Health Plan and the network of providers that applies is the Prevea 360 ASO Network.

53001	53061	53093	54131	54162	54207	54217	54235	54305
53011	53062	54101	54137	54165	54208	54220	54240	54306
53013	53063	54106	54139	54166	54209	54221	54241	54307
53015	53070	54107	54140	54171	54210	54226	54245	54308
53020	53073	54111	54141	54173	54211	54227	54246	54311
53023	53075	54112	54153	54180	54212	54228	54247	54313
53026	53081	54115	54154	54201	54213	54229	54301	54324
53031	53082	54124	54155	54202	54214	54230	54302	54344
53042	53083	54126	54157	54204	54215	54232	54303	
53044	53085	54130	54161	54205	54216	54234	54304	

APPENDIX B

PREVEA 360/HEALTHEOS NETWORK SERVICE AREA

If your primary home residence is in Eastern Wisconsin as defined by the zip code list below, your HSHS Healthy Plan coverage is administered by Dean Health Plan and the network of providers that applies is the Prevea 360 ASO Network and HealthEOS network.

53002	53051	53109	53181	53224	53594	54159	54911	54961
53003	53052	53110	53182	53225	53916	54160	54912	54962
53004	53056	53118	53183	53226	53922	54169	54913	54963
53005	53057	53119	53185	53227	53926	54170	54914	54964
53006	53058	53122	53186	53228	53931	54174	54915	54965
53007	53059	53126	53187	53233	53933	54175	54919	54966
53008	53060	53127	53188	53234	53939	54177	54922	54967
53010	53064	53129	53189	53235	53946	54182	54923	54968
53012	53065	53130	53192	53237	53947	54409	54926	54969
53014	53066	53132	53194	53244	53956	54414	54927	54970
53016	53069	53137	53199	53259	53963	54416	54928	54971
53017	53072	53139	53201	53263	54102	54418	54929	54974
53018	53074	53140	53202	53267	54103	54424	54930	54976
53019	53076	53141	53203	53268	54104	54427	54931	54977
53021	53078	53142	53204	53274	54110	54428	54932	54978
53022	53079	53143	53205	53278	54113	54430	54933	54979
53024	53080	53144	53206	53288	54114	54450	54934	54980
53027	53086	53146	53207	53290	54119	54462	54935	54981
53029	53088	53149	53208	53293	54120	54464	54936	54982
53032	53089	53150	53209	53295	54121	54465	54937	54983
53033	53090	53151	53210	53401	54123	54485	54940	54984
53034	53091	53152	53211	53402	54125	54486	54941	54985
53035	53092	53153	53212	53403	54127	54491	54942	54986
53036	53094	53154	53213	53404	54128	54499	54943	54990
53037	53095	53156	53214	53405	54129	54511	54944	
53038	53097	53158	53215	53406	54135	54520	54945	
53039	53098	53159	53216	53407	54136	54541	54946	
53040	53099	53167	53217	53408	54138	54542	54947	
53045	53101	53168	53218	53490	54143	54566	54948	
53046	53102	53170	53219	53538	54149	54901	54949	
53047	53103	53171	53220	53549	54150	54902	54950	
53048	53104	53177	53221	53551	54151	54903	54952	
53049	53105	53178	53222	53557	54152	54904	54956	
53050	53108	53179	53223	53579	54156	54906	54957	

NOTICE OF PRIVACY PRACTICES

Effective 01/01/2013

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

WHO WILL FOLLOW THIS NOTICE?

This notice describes the practices of Hospital Sisters Health System ("HSHS") health plan (the "Plan") and the practices that will be followed by all HSHS Colleagues who handle your protected health information (PHI) in the administration of the Plan benefits to you and your covered dependent(s).

OUR PLEDGE REGARDING YOUR PHI

The HSHS Plan understands that PHI about you and your health is personal. We are committed to protecting PHI about you. We maintain our records in administering the HSHS Plan with a goal of providing the highest level of protection for your PHI. This notice applies to all of the records of your medical care which are received by the HSHS Plan.

Your medical Treatment providers (e.g., doctors, hospitals, home health agencies, etc.) may have different policies or notices regarding the use and disclosure of your PHI.

This notice will tell you about the ways in which the HSHS Plan may use and disclose PHI about you. We also describe your rights and certain obligations the HSHS Plan has regarding the use and disclosure of PHI. We are required by law to:

- make sure that PHI that identifies you is kept private;
- give you this notice of our legal duties and privacy practices with respect to PHI about you; and
- follow the terms of the Notice that is currently in effect.

PERMITTED USES & DISCLOSURES FOR TREATMENT, PAYMENT, & HEALTH CARE OPERATIONS

By enrolling in the HSHS Plan, you are giving consent for the HSHS Plan, Business Associates and their agents/subcontractors, if any, to use your PHI for certain activities, including treatment, payment, and other health care operations.

Treatment is the provision, coordination or management of health care and related services by one or more Health Care Providers. It also includes, but is not limited to, consultations and referrals between one or more of your providers.

For example, the Plan may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental X-rays from the treating dentist.

Payment means activities undertaken by the Plan to obtain premiums or to determine or fulfill its responsibility for coverage and provision of benefits under the Plan, or to obtain or provide reimbursement for the provision of health care. Payment includes, but is not limited to, actions to make eligibility or coverage determinations, billing, claims management, collection activities, subrogation, reviews for Medical Necessity and appropriateness of care, utilization review and pre-authorizations.

For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill might be paid by the Plan.

Health care operations means conducting quality assessment and improvement activities, population-based activities relating to improving health or reducing health care costs, contacting Health Care Providers and patients information about Treatment alternatives, reviewing the competence or qualifications of health care professionals, evaluating health plan performance, underwriting, premium rating and other insurance activities relating to creating, renewing or replacing health insurance contracts or health benefits. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse detection and compliance programs, business planning and development, business management and general administrative activities.

For example, the Plan may use information about your Claims to refer you to a disease management program, project future benefit costs or audit the accuracy of its claims processing functions.

We may use and disclose PHI about you so that those who provide you medical Treatment or services under the HSHS Plan may be paid. We may also use and disclose PHI about you for HSHS Plan operations.

The following uses of your PHI may be made without any additional authorization from you. (Not every use or disclosure is listed, but be assured that all uses and disclosures made by the HSHS Plan are only those which are permitted under the law):

- Enrollment in and removal from the health plan
- Health claims processing and related customer services activities
- Health claim payment and remittance advice such as Explanation of Benefits (EOB) forms
- Determinations of eligibility
- Health care premium payments (including payments under continuation of benefits)
- Health care claim status
- Coordination of benefits, subrogation, and overpayments
- Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs
- Medical case management
- Activities relating to reinsurance and filing of reinsurance claims
- In compliance with a request from an authorized governmental agency.

USES AND DISCLOSURE FOR HEALTH-RELATED BENEFITS OR SERVICES

From time to time we may use and disclose PHI to tell you about Treatment alternatives or other health-related benefits or services that may be of interest to you.

USES AND DISCLOSURES REQUIRED BY LAW

We will disclose PHI about you when required to do so by federal, state, or local law.

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES

We may disclose PHI to a health oversight agency for activities authorized by law. These activities include, for example, audits, investigations, and inspections. These activities are necessary for the government to monitor the health care system, the delivery of health care, etc.

DISCLOSURES FOR LAWSUITS AND DISPUTES

If you are involved in a lawsuit or a dispute, we may disclose PHI about you in response to a court order or administrative order. We may also disclose PHI about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

DISCLOSURES TO LAW ENFORCEMENT

We may release PHI if asked to do so by a law enforcement official, in response to a court order, subpoena, warrant, summons, or similar process. Other related disclosures may include disclosures to national security and intelligence agencies, as well as disclosures to authorized federal officials for the protection of the President of the United States or other authorized persons or foreign heads of state.

DISCLOSURES TO PLAN SPONSOR

The HSHS Plan may, from time to time, disclose information about you to the Plan Sponsor.

DISCLOSURES FOR WORKERS COMPENSATION

We may release PHI when authorized by and to the extent necessary to comply with workers compensation or other similar programs established by law.

YOUR RIGHTS REGARDING PHI ABOUT YOU

Right to Inspect and Copy. You have the right to inspect and copy PHI contained in a "designated record set" that may be used to make decisions about your medical care. Usually this right includes both medical and billing records. You must submit your request in writing. If you request a copy of the information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. Your request to inspect and copy your information may only be denied in very limited circumstances and you have a right to request that any such denial be reviewed.

"Designated Record Set" means a group of records maintained by or for a health plan that is enrollment, payment, claims adjudication and case or medical management record systems maintained by or for a health plan; or used in whole or in part by or for the health plan to make decisions about individuals. Information used for quality control or peer review analysis and not used to make decisions about individuals is not in the designated record set.

The Plan will act on a request for access no later than 30 days after receipt of the request. However, if the request for access is for PHI that is not maintained or accessible to the Plan on-site, the Plan must take action no later than 60 days from the receipt of such request. The Plan must take action as follows: if the Plan grants the request, in whole or in part, the Plan must inform you of the acceptance and provide the access requested. However, if the Plan denies the request, in whole or in part, the Plan must provide you with a written denial. If the Plan cannot take action within the required time, the Plan may extend the time for such action by no more than 30 days if the Plan, within the applicable time limit, provides you with a written statement of the reasons for the delay and the date by which it will complete its action on the request.

Right to Request Restrictions. You have the right to request we restrict the use of your PHI for Treatment, payment and health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency Treatment under the HSHS Plan. To request restrictions, you must make your request in writing to your People Services Department. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.

Right to Confidential Communications. You also have the right to request to receive private health information communications (such as EOB's) by alternative means or at alternative locations. For example, you can ask that we only contact you at work or by mail. To request confidential communications, you must make your request to the People Services department in writing. Your request must specify how or where you wish to be contacted.

Right to Amend. If you feel that the PHI we have about you is incorrect or incomplete, you have the right to request that your PHI be amended. Only the health care entity (e.g., doctor, Hospital, clinic, etc.) that created your PHI is responsible for amending it. For more information regarding the procedures for submitting such a request, contact Privacy Officer, Hospital Sisters Health System, PO Box 19456, Springfield, IL 62794-9456.

Right to an Accounting of Disclosures. You have a right to an accounting of disclosures of your PHI, for purposes other than payment or health care operations by the HSHS Plan or any of the people or companies who perform Treatment, payment, or health care operations on our behalf. To request this list of disclosures we made of PHI about you, you must submit a request in writing to your People Services Department. Your request must state a time period, which may not be longer than six (6) years prior to the date of your request and may not include dates before April 14, 2003. Your request should indicate the form in which you want the list (for example, on paper or electronically).

If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting unless you withdraw or modify the request for a subsequent accounting to avoid or reduce the fee.

Right to a Paper Copy of this Notice. You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time.

To learn more about this procedure, or to make this request, you should contact the People Services Dept.

NOTICE

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices with respect to PHI.

This Notice is effective beginning on the effective date set forth on the first page of this Notice, and the Plan is required to comply with the terms of this Notice. However, the Plan reserves the right to change the terms of this Notice and to make the new revised notice provisions effective for all PHI that it maintains, including any PHI created, received or maintained by the Plan prior to the date of the revised notice. If a privacy practice is changed, a revised version of this Notice will be provided to all individuals then covered by the Plan. If agreed upon between the Plan and you, the Plan will provide you with a revised Notice electronically. Otherwise, the Plan will mail a paper copy of the revised Notice to your home address. (Privacy Practices will include Policies and Procedure.)

Any revised version of this Notice will be distributed within 60 days of any material change to the uses or disclosures, the individual's rights, the duties of the Plan or other privacy practices stated in this Notice. Except when required by law, a material change to any term of this Notice may not be implemented prior to the effective date of the revised notice in which such material change is reflected.

CHANGES TO THIS NOTICE

HSHS reserves the right to change this notice. We reserve the right to make the revised or changed notice effective for PHI we already have about you, as well as any information we receive in the future. The notice will contain the effective date.

COMPLAINTS

If you believe your privacy rights have been violated and that HSHS has not followed this policy, you may file a complaint with Privacy Officer or with the Secretary of the Department of Health and Human Services. To file a complaint with HSHS, contact Privacy Officer, Hospital Sisters Health System, PO Box 19456, Springfield, Illinois 62794-9456. All complaints must be submitted in writing. You will be contacted within 30 days. **You will not be penalized or retaliated against for filing a complaint.**

OTHER USES OF PHI

Other uses and disclosures of your PHI not covered by this notice or the laws that apply to HSHS will be made only with your written permission ("authorization"). If you provide us permission to use or disclose PHI about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose PHI about you for the reasons covered by your authorization. You understand that we are unable to take back any disclosures we have already made with your permission, and that we are required to retain our records of the health plan benefits that we have administered to you.

QUESTIONS?

If you have any questions regarding this notice, please contact Privacy Officer, Hospital Sisters Health System, PO Box 19456, Springfield, Illinois 62794-9456.

HSHS | Benefit Questions?
1-855-FYI-HSHS

Colleague Service Center