FLEXPLAN

The benefits of choice

Dental Insurance Plan

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DEFINITIONS

Active Employment: You must be working for your Employer on a regularly scheduled (budgeted) basis, a minimum of 32 hours per biweekly pay period. Normal vacation is considered Active Employment. An absence for any other reason is not considered Active Employment.

Affiliate: One of the Employers listed in the Eligibility section of this document.

Claims Administrator: Cigna

Colleague: Means a person who is in Active Employment with us (same as employee).

Dentist: The term Dentist means a person practicing dentistry or oral surgery within the scope of his/her license. It will also include a physician operating within the scope of his/her license when he/she performs any of the dental services described in the Policy.

Employer: Hospital Sisters Health System and its Affiliates.

Covered Expenses: The term Covered Expenses means expenses incurred by or on behalf of you or any one of your Dependents for charges made by a Dentist for the performance of a dental service that is covered by the Plan.

Covered Expenses will include only those expenses incurred for such charges when the dental service:

- Is performed by or under the direction of a Dentist;
- Is essential for the necessary care of the teeth; and
- For other than orthodontia services, starts and is completed while the person is insured under this Plan.

Any portion of charges for a dental service that exceeds the maximum covered expense is not included. A dental service is deemed to start when the actual performance of the service starts except that:

- For fixed bridgework and full or partial dentures, it starts when the first impressions are taken and/or abutment teeth fully prepared.
- For a crown, inlay or onlay, it starts on the first date of preparation of the tooth involved.
- For root canal therapy, it starts when the pulp chamber of the tooth is opened.

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

DMO: Dental Maintenance Organization.

Legally Domiciled Adult (LDA): an individual over 18 who has for at least 6 months lived in the same principal residence as the Colleague and remains a member of the Colleague's household during the coverage period; and who either: (A) has an on-going, exclusive and committed relationship with the Colleague similar to marriage (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the Colleague, is neither legally married to anyone else nor legally related to the Colleague by blood in any way that would prohibit marriage; or (B) is the Colleague's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period.

Medically Necessary: A treatment will be considered medically necessary with respect to a specific condition if its clinical efficacy has been generally accepted by the medical community in the United States, and if it satisfies all of the following:

- It is legal;
- It is ordered by a physician or other personnel licensed to treat that condition;

- It is administered with the appropriate frequency, quantity, duration and level of service; and
- It is not redundant when combined with other treatment being rendered.

Plan: Flexplan Dental Insurance Plan

Plan Administrator: Hospital Sisters Health System (HSHS)

Plan Sponsor: Hospital Sisters Health System (HSHS)

Plan Year: The calendar year.

Reasonable and Customary Charges: The charge made by a Dentist or supplier of services, medicines, or supplies which does not exceed the general level of charges made by others rendering or furnishing such services, medicines, or supplies, within an area in which the charge is incurred for conditions or injuries comparable in severity and nature to the condition or injury being treated.

Us: refers to the Plan Sponsor (Hospital Sisters Health System).

You: Refers to you, the Colleague, if insured under this Plan.

ELIGIBILITY
ELIGIBLE COLLEAGUES

To be eligible for coverage under this Plan:

1. You must be a Colleague of one of the following:
   - St. Elizabeth's Hospital – O'Fallon, 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
   - 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
   - Holy Family Hospital – Greenville, Illinois
   - 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 per bi-weekly pay period. Temporary and leased Colleagues are not eligible to participate in the Plan;
3. Medical residents on St. John's Hospital – Springfield, Illinois payroll
4. Carpenters and painters employed by St. John's Hospital—Springfield, Illinois that are members of a collective bargaining unit are not eligible to participate in this Plan.; and
5. Coverage will begin the first day of the pay period following two full bi-weekly pay periods of Active Employment in a benefits-eligible status.

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 that transfer to an HSHS affiliate from one of the above 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.

6. For colleagues of Good Shepherd, employment with Good Shepherd will be considered employment with HSHS for individuals that transfer to an HSHS Affiliate that is identified in item 1 above with no lapse in employment between Good Shepherd and HSHS. Individuals

that transfer to an HSHS affiliate from Good Shepherd, 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 and they meet the Plan's other eligibility requirements.

7. Special eligibility provisions apply to individuals that become Colleagues of an HSHS participating Affiliate as a direct result of a business acquisition, provided that the Colleague meets the Plan's eligibility requirements, other than the applicable employment period requirement, and there is no lapse in employment between that entity and the HSHS affiliate. Refer to *Special Eligibility Provisions Applicable to HSHS Acquisitions.*

DEPENDENT ELIGIBILITY

Your dependents eligible for coverage from 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 Claims Administrator.
- A Legally Domiciled Adult (LDA) in lieu of covering a legal spouse. A Legally Domiciled Adult (LDA) is an individual over 18 who has for at least 6 months lived in the same principal residence as you and remains a member of your household during the coverage period; and who either: (A) has an on-going, exclusive and committed relationship with you similar to marriage (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with you, is neither legally married to anyone else nor legally related to you by blood in any way that would prohibit marriage; or (B) is your blood adult relative who meets the definition of your tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period.

A "child" is your natural born child, stepchild, legally adopted child, or child who is being adopted and is still within the adoption process. A foster child can be considered a dependent when the adoption process is in progress. A child of a covered LDA is eligible for coverage if the LDA is the birth parent, legally adoptive parent, or legal guardian of the child.

Coverage is also extended to children when, in addition to the basic requirements with respect to age:

- You are their legal guardian.
- You have legal custody and the child is otherwise considered dependent on you.
- You have assumed responsibility for the child of your child (your grandchild). 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.

If you and your spouse or LDA both work for a participating employer, you may each enroll for coverage as a Colleague, or one of you may be enrolled as a Dependent of your spouse or LDA. 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.

WHEN COVERAGE BEGINS

Your coverage starts on the date you become eligible provided you enroll and authorize the required contributions on or before that date.

WHEN COVERAGE BEGINS FOR YOUR DEPENDENTS

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

If you acquire an eligible dependent (through marriage, birth or adoption, for example) after you become covered by the Plan, 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.

LATE ENROLLMENT

If you do not enroll in the Dental Plan when initially eligible or you decline Plan participation during the annual Flexplan re-enrollment period, you will not be eligible for Plan participation again for two Plan Years. However, if you decline participation because you are covered under your spouse's dental plan and your spouse becomes ineligible for that coverage, you can enroll in this Plan, provided you do so within 30 days of losing dental coverage through your spouse.

CHANGING YOUR DENTAL PLAN COVERAGE

Normally, you can only change your coverage during the annual enrollment period, which occurs at the end of each year for the following 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/LDA, 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 who meets the requirements specified in the ***Dependent Eligibility*** section.
- **Your spouse or LDA, 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 dental plan** - you may add your spouse, LDA and/or eligible children previously covered under that plan to the HSHS Dental Plan.
- **Change in work status for you, your spouse or LDA, 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 dental eligibility.
- **Your child satisfies or ceases to satisfy the Dependent Eligibility requirements** specified in the ***Dependent Eligibility*** section.
- **Change in other dental coverage as a result of your spouse's or LDA's employer's annual enrollment -** If you and/or your eligible dependents become covered by or lose coverage through another dental plan as a result of your spouse's or LDA's employer's annual enrollment which occurs at a different time than that of this Plan, you may change your HSHS Dental Plan coverage accordingly. However, your election to change your coverage must be made within 30 days of when your spouse's or LDA's dental coverage change becomes effective.

Change in other dental 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 dental 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 Dental Plan coverage accordingly. However, your election to change your coverage must be made within 30 days of when your child's dental coverage change becomes effective.

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

If you experience a qualified status change, you must contact your benefits representative to complete the necessary forms within 30 days. Any change in your dental coverage election must be consistent with the qualified change in status.

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

- If you decide not to enroll in this Plan, you cannot enroll in either of the dental options for two calendar years following the date you first waive coverage. This means that if you waive coverage for 2018, you will not be eligible to enroll again until the fall of 2019 for the coverage starting January 1, 2020, unless you waive coverage because you are covered by your spouse's or LDA's plan and your spouse or LDA becomes ineligible for that coverage.
- You may add or drop coverage for yourself or your dependents during the annual enrollment period. However, if you or your dependent has started a program of orthodontic treatment under the High Option, you must continue the High Option until an open enrollment period that follows the completion of active orthodontic treatment for any such person.

TRANSFER POLICY

If you're covered by the Plan when you change employment from one Affiliate to another, your coverage will be continuous, provided you complete the necessary payroll authorization forms promptly.

THE COST OF YOUR COVERAGE

You and your employer share the cost of coverage under the Plan. Your contributions for coverage are deducted from your paycheck on a before-tax basis under Flexplan unless you are covering a LDA who is not a federal tax dependent. For a LDA who is not a federal tax dependent, contributions toward the LDA's portion of the cost must be paid on an after-tax basis.

Using the before-tax method, your 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 contributions. For after-tax contributions for a LDA that is not a federal tax dependent, the amount paid toward the cost of the LDA's coverage will be taxable income called "imputed income". Imputed income will be applied to each paycheck.

You should be aware that the use of salary reduction to purchase insurance 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. 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.

When you elect coverage under this insurance plan, you will automatically be enrolled for before-tax contributions under Flexplan unless you cover an LDA that is not a federal tax dependent. Those contributions must be paid on an after-tax basis.

You can change this election once each year during the annual enrollment period. You also may change your election if you have a qualifying change in family status.

FAMILY LEAVE OR MEDICAL LEAVE

If a Colleague is on a family leave or medical leave of absence, coverage will continue under the policy, in accordance with the employer's Human Resource 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 for the Colleague; and
- The Employer has approved the Colleague's leave in writing.

Coverage under the Plan for the Colleague and any 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.

Any pre-existing limitation or waiting period will be waived upon return from leave providing these requirements were met prior to the leave.

DENTAL PLAN COVERAGE/OPTIONS

PLAN CHARACTERISTICS	BASIC	HIGH
Annual Deductibles Per Individual Family Limit	 $50 $150	 $25 $75
Diagnostic and Preventive Services (Class I)	No Deductible Plan Pays 100%	No Deductible Plan Pays 100%
General Restorative Services (Class II)	After Deductible Plan Pays 85%	After Deductible Plan Pays 85%
Replacements and Other Major Services (Class III)	After Deductible Plan Pays 50%	After Deductible Plan Pays 50%
Orthodontia Services (Class IV) Lifetime Maximum	No Coverage	Additional $25 Deductible Plan Pays 50% $1,500
Yearly Maximum Benefit All Services * Except for Orthodontia Services	$800	$1,500*

The HSHS Dental Plan provides coverage for you and your Dependents in four major categories:

1. **DIAGNOSTIC AND PREVENTIVE SERVICES (CLASS I)**

The maximum covered expense is 100% of the Reasonable and Customary charge for the following services:

- Periodic Oral Examination & Cleaning – Two per person in any calendar year period. In the case of periodontal disease, a third cleaning is covered. Only the diagnosis and prior treatment of periodontal disease allows for the third cleaning.
- Emergency Treatment – To relieve dental pain when no other definitive dental services are performed. (Any x-ray taken in connection with such treatment is a separate dental service.)
- X-Rays – Complete series (with or without bitewing x-ray) – one per person, including panoramic film, in any 36 consecutive months.
- Bitewing X-Rays – No more than two charges per person in any calendar year period.
- Panoramic (Panorex) X-ray – One per person in any 36 consecutive months.
- Periodontal Prophylaxis.
- Topical application of acid fluoride phosphate – limited to persons less than 19 years old. Two per person in any calendar year period.
- Topical application of sealant on a posterior tooth. One treatment per tooth in any 36 consecutive months.
- Space maintainers, fixed unilateral – limited to non-orthodontic treatment.
- Transepithelial sample collection (brush biopsy).

2. **GENERAL RESTORATIVE SERVICES (CLASS II)**

This includes Endodontics, Periodontics, Prosthodontic Maintenance and Oral Surgery. The maximum covered expense is 85% of the Reasonable and Customary Charge for the following services:

- Amalgam Filling – Primary (Baby) Teeth, One Surface.
- Amalgam Filling – Permanent Teeth, One Surface.
- Composite Acrylic Resin Filling, One Surface.
- Root Canal Therapy – Any x-ray, test, laboratory exam or follow up care is part of the allowance for root canal therapy and not a separate dental service.
- Osseous Surgery – Flap entry and closure is part of the allowance for osseous surgery and osseous graft and not a separate dental service.

If more than one periodontal surgical service is performed per quadrant, only the one with the largest maximum covered expense is a dental service.

- Periodontal Scaling and Root Planing
- Adjustments – Complete Denture. Any adjustments of or repair to a denture within 6 months of its installation is not a dental service.
- Re-cement Bridge.
- Simple Extractions.
- Surgical Extractions – Soft Tissue, Partial Bone or Complete Bone Impaction (see *"Coordination with Health Insurance Plan"*).
- Local Anesthetic, Analgesic and routine postoperative care for extractions and other oral surgery are part of the allowance for each Dental Service.
- General Anesthetic – The administration of a general anesthetic is a dental service covered (a) when Medically Necessary in conjunction with oral or dental surgery; or (b) if the anesthetic agent produces a state of unconsciousness with absence of pain sensation over the whole body.

3. **REPLACEMENTS AND OTHER MAJOR SERVICES (CLASS III)**

This includes major restorations, dentures and bridgework. The maximum covered expense is 50% of the reasonable and customary charge for the following services:

- Crowns–Porcelain with gold, cast gold – full or cast gold - three fourths. Gold or crown restorations are dental services only when the tooth, as a result of extensive caries or fracture, cannot be restored with amalgam, silicate, acrylic or plastic restoration.
- Fixed or Removable Appliances – Complete (full) dentures, upper or lower.
- Partial Dentures – Acrylic base. Lower, with two clasps and chrome lingual bar; Upper, with two clasp and chrome palatal bar.
- Bridge Pontics – Cast gold.
- Bridge Pontics – Porcelain fused to gold.
- Bridge Pontics – Plastic processed to gold.
- Abutment Crowns – Plastic processed to gold.
- Abutment Crowns – Porcelain fused to gold.
- Abutment Crowns – Full case gold.
- Prosthesis over Dental Implant - Allows for crowns, bridges, and partial or full dentures that attach to dental implant.
- Replacement of missing teeth - For first replacement of teeth that are missing when a person

becomes insured or in the case of a late entrant into the Plan, benefits are limited to 25%. After a person has been continuously insured for 24 months, benefits will be paid at 50%.

4. **ORTHODONTIA (CLASS IV) High Dental Option Only**

The maximum covered expense is 50% of the reasonable and customary charge up to a lifetime maximum of $1,500. Each month of active treatment is a separate dental service.

A preliminary study is provided which includes x-rays, diagnostic costs and a treatment plan. The first month of active treatment and retention appliances are covered.

Following is the treatment provided after the first month:

- Fixed or Cemented Appliance – One appliance per person.
- Tooth Guidance – One arch per person.
- Control of Harmful Habits – One appliance per person.

The total amount payable for all expenses incurred for orthodontics during a person's lifetime will not be more than the orthodontia maximum of $1,500.

Payments for Comprehensive Full Banded Orthodontia Treatments are made in installments. Payment of benefits will be made every 3 months. The first payment becomes payable when the appliance is installed. Later payments are payable at the end of each 3 month period. In determining the first installment, 25% of the charge is assigned for the entire course of treatment to the appliance. The rest of such charge is prorated over the estimated duration of such treatment. These payments are made only for services performed while a person is insured. If insurance or treatment ceases during a period, the amount payable for that period will be prorated.

OTHER IMPORTANT PROVISIONS

DEDUCTIBLE UNDER BASIC AND HIGH OPTIONS

If you or any one of your Dependents incur Covered Expenses, the Plan will:

- Deduct any dental deductible that applies from the Covered Expenses first incurred in a Plan Year for a person, exclusive of ***DIAGNOSTIC AND PREVENTIVE SERVICES***; and
- Pay for the other Covered Expenses incurred in that Plan Year up to the maximum covered expense determined from the dental services schedule for each dental service subject to the alternate benefit provision.

FAMILY DEDUCTIBLE LIMIT – BASIC

After dental deductibles totaling $150 have been applied in a Plan Year for either (a) you and your Dependents or (b) your Dependents, any dental deductible will be waived for your family for the rest of that year.

FAMILY DEDUCTIBLE LIMIT – HIGH

After dental deductibles totaling $75 have been applied in a Plan Year for either (a) you and your Dependents or (b) your Dependents, any dental deductible will be waived for your family for the rest of that year.

MAXIMUM BENEFIT PROVISION

The total amount payable for all expenses incurred for other than orthodontics for a person in a calendar year will not be more than the maximum benefit shown in the schedule.

ALTERNATE BENEFIT PROVISION

When more than one dental service could provide suitable treatment based on common dental standards, the Plan Administrator will determine the dental service on which payment will be based and the expenses that will be included as Covered Expenses.

PREDETERMINATION OF BENEFITS

Predetermination of benefits means a review by the Plan Administrator of a Dentist's description of planned treatment and expected charges, including those for diagnostic x-rays. This review should be made whenever extensive dental work is proposed. The information should be sent to the Plan Administrator before the dental work is started. If there is a major change in the treatment plan, a revised plan should be sent to the Plan Administrator.

The expenses that will be included as Covered Expenses will be determined by the Plan Administrators and are subject to the alternate benefit provision. When there has not been a predetermination of benefits, the Plan Administrator will determine the expenses that will be included as Covered Expenses at the time the claim is received.

Predetermination of benefits does not guarantee payment. The estimate of benefits payable may change based on the benefits, if any, for which a person qualifies at the time services are completed.

Covered dental expenses will include expenses incurred for dental services listed in this schedule. The Plan Administrator may agree to accept, as covered dental expenses, expenses for services not listed. To be considered, services should be identified in terms of the American Dental Association Uniform Code on Dental Procedures and Nomenclature and/or by description and submitted to the Plan Administrator.

The Plan Administrator will determine the maximum covered expense for services that it accepts. The maximum covered expense so determined will be consistent with the maximums listed. A temporary dental service is included in the allowance for the final dental service and is not a separate dental service.

COORDINATION OF BENEFITS

Because the sole purpose of dental care coverage is to help meet actual dental expenses, nearly all group dental plans contain a "coordination of benefits" requirement. Coordination of benefits applies to any situation in which you (or any of your Dependents) are also eligible for coverage under any other plan of dental benefits. It means that you and/or your Dependents covered under this Plan and any other plan of dental benefits will be reimbursed up to 100% of your Covered Expenses. But under no circumstances will the total benefits available exceed 100%.

Simply stated, coordination of benefits works like this: If you are covered by more than one plan of group dental benefits, not including DMO's, 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.

This Plan does not coordinate benefits with DMO's. If a Colleague or his/her Dependent(s) is covered under a DMO, any expenses that are not reimbursed by the DMO are not covered under this Plan.

PLAN

Plan means any of the following which provides medical or dental benefits or services: (a) group or blanket insurance coverage; (b) service plan contracts, group or individual practice or other prepayment plans; or (c) coverage under any labor-management trusteed plans; union welfare plans; employer organization plans; or employee benefit organization plans. Plan does not include coverage under individual or franchise policies or contracts. Each Plan or part of a Plan which has the right to coordinate benefits will be considered a separate Plan.

ALLOWABLE EXPENSE

Allowable expense means any necessary, reasonable and customary item of expense at least a part of which is covered by any one of the Plans that covers the person for whom a claim is made.

CLAIM DETERMINATION PERIOD

Claim Determination Period means a Plan Year or that part of a Plan Year in which the person has been covered under this Plan.

BENEFIT DETERMINATION RULES

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

1. The benefits of a Plan which covers the person or whom a claim is made other than as a dependent will be determined before a Plan which covers that person as a dependent.
2. The benefits of a Plan which covers the person for whom a claim is made as a dependent of a person whose day of birth occurs first in a calendar year will be determined before a Plan which covers that person whose day of birth occurs later in that year; except that; (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 benefits 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 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 4a, which results in each Plan determining its benefits after the other, then item 4a will not apply.

PAYMENT OF BENEFITS TO WHOM PAYABLE

All dental benefits under either Basic or High are payable to you. However, at the option of the Plan Sponsor, all or any part of the dental benefits under either Basic or High may be paid directly to the person or institution on which charge the claim is based.

If you die while dental benefits under either Basic or High remain unpaid, the Plan Sponsor may choose to make direct payment to any of the following living relatives: spouse, mother, father, child or children, brothers or sisters, or to the executors or administrators of your estate.

If any person to whom benefits are payable is a minor or, in the opinion of the Plan Sponsor, is not able to give a valid receipt for any payment due him, such payment will be made to his legal guardian. However, if no request for payment has been made by his legal guardian, the Plan Sponsor may, at its option, make payment to the person or institution appearing to have assumed his custody and support.

Payment as described above will release the Plan Sponsor from all liability to the extent of any payment made.

COORDINATION WITH HEALTH INSURANCE PLAN

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

Please request that your provider submit claims for these services to Aetna or Dean Health Plan, as appropriate. Refer to the HSHS Healthy Plan Summary Plan Description booklet.

Once your claim for extraction or excision of impacted teeth has been processed by Aetna or Dean Health Plan, you may then submit any expenses not paid by the HSHS Healthy Plan to this Plan for consideration.

EXCLUSIONS AND LIMITATIONS

Covered Expenses under Basic and High will not include and no payment will be made for:

- ⊗ Dental services that do not meet common dental standards;
- ⊗ Services that are deemed to be medical services (HSHS Healthy Plan has limited dental coverage);
- ⊗ Services and supplies received from a hospital;
- ⊗ Services performed solely for cosmetic reasons;
- ⊗ Replacement of a lost or stolen appliance;
  - ⊗ Replacement of a bridge, crown or denture within five years after the date it was originally installed unless: (a) the replacement is made necessary by the placement of an original opposing full denture or the necessary extraction of natural teeth; or (b) the bridge, crown or denture, while in the mouth, was damaged beyond repair as a result of an injury received while a person is insured for these benefits;
  - ⊗ Procedures, appliances or restorations (except full dentures) whose main purpose is to: (a) change vertical dimension; (b) diagnose or treat conditions or dysfunction of the temporomandibular joint (TMJ); (c) stabilize periodontally involved teeth; or (d) restore occlusion;
  - ⊗ Porcelain or acrylic veneers on crowns or pontics on or replacing the upper and lower first, second and third molars; bite registrations; precision or semi-precision attachments; or splinting;
- ⊗ Surgical implant of any type;
- ⊗ Instruction for plaque control, oral hygiene and/or diet as separate services.
  - ⊗ Procedures performed by a Dentist who is a member of the covered person's family (covered person's family includes a spouse, siblings, parents, children, grandparents, and the covered person's spouse's siblings and parents.)

GENERAL LIMITATIONS

No payment will be made for expenses incurred or services received:

- ⊗ For or in connection with an injury arising out of, or in the course of, any employment for wage or profit (i.e. self-employment); or in connection with an injury or sickness which is covered under any worker's compensation or similar law;
- ⊗ In a hospital owned or run by the United States Government unless the person is legally required to pay for such charges;
- ⊗ To the extent that payment is unlawful where the person resides when the expenses are incurred or the services are received;
- ⊗ Which the person would not be legally required to pay;
- ⊗ To the extent that they are more than Reasonable and Customary Charges;
- ⊗ For unnecessary care, treatment or surgery;
- ⊗ To the extent that you or any of your Dependents are in any way paid or entitled to payment for those expenses or services by or through a public program, other than Medicaid;
- ⊗ For or in connection with experimental procedures or treatment methods not approved by the American Dental Association or the appropriate dental specialty society.

No payment will be made for expenses incurred or services received by you or any of your Dependents to the extent that benefits are paid or payable for those expenses or services under the mandatory part of any auto insurance policy written to comply with:

- a "no-fault" insurance law; or
- an uninsured motorist insurance law.

The Plan Sponsor will take into account any adjustment option chosen under such policy by you or any of your Dependents.

TERMINATION OF COVERAGE

Your coverage under this Plan 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 Right 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 to the above, coverage for each Dependent ends on the earliest of the following:

- On the date your coverage ends.
- On the date a Dependent no longer satisfies the eligibility requirements specified in the ***Dependent Eligibility***.
- On the date that Dependent becomes covered as a Colleague participant in this Plan.
- On the date you request that coverage for your Dependent(s) end (must coincide with a "qualified status change" as outlined in ***Changing Your Dental Plan Coverage*** or Annual Enrollment).

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, LDA or child that you have enrolled in the Plan ceases to meet the eligibility requirements of the Plan, it is your responsibility to notify your Human Resources department. 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.

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.

1. A Colleague whose coverage would otherwise terminate (except those discharged for misconduct in connection with employment);
2. The former spouse of a Colleague whose coverage would otherwise cease due to divorce or annulment;
3. The Dependent of a deceased Colleague;
4. A Dependent child who reaches the limiting age.
5. 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 Human Resources department within 30 days of the qualifying event. You may continue your group coverage for up to a maximum of 18 months.

Premiums must be paid totally by the participant and the premium payment must be received at the beginning of each pay period you wish to continue group coverage.

TERMINATION OF CONTINUATION COVERAGE

This continued 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.

DENTAL BENEFITS EXTENSION

A dental service that is completed after a person's benefits cease will be deemed to be completed while he is insured if:

- For fixed bridgework and full or partial dentures, the first impressions are taken and/or abutment teeth fully prepared while he is insured and the device installed or delivered to him within 3 calendar months after his insurance ceases.
- For a crown, inlay or onlay, the tooth is prepared while he is insured and the crown, inlay or onlay installed within 3 calendar months after his insurance ceases.
- For root canal therapy, the pulp chamber of the tooth is opened while he is insured and the treatment is completed within 3 calendar months after his insurance ceases.

There is no extension for any Dental Service not shown above.

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. HSHS may charge up to 102% of the full cost of coverage for periods of service equal to or exceeding 31 days.

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 and pre-existing conditions limitation generally will not apply to your reinstated coverage. However, you may be required to satisfy any pre-existing condition exclusion or waiting period that would apply if there had been no break in coverage and 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 PROCEDURES

All claim forms may be obtained from Cigna or your Human Resources department. Instructions on the claim form should be followed carefully. This will expedite processing the claim. Be sure all questions are answered fully, including the completion or attachment of any required medical statements. A separate claim form is required for each individual. Return the completed form within 90 days after the date of service to:

Cigna
P.O. Box 188037 Chattanooga, TN 37422-8037
1-800-CIGNA24
1-800-244-6224

When the claim has been processed, you will be notified of the benefits paid. If any benefits have been denied, you will receive a written explanation. (See example on next page).

Ordinarily a decision on your claim will be made by Cigna within 30 days. If there are special circumstances which require more time to process your claim, you will be sent a notice, within the 30 day period, explaining why more time is needed.

You or your provider may submit claim requests any time during the calendar year, January 1st through December 31st. All claims incurred during a calendar year must be received by Cigna no later than one year from the date you received the service (date of service). No payment will be issued for claims submitted after one year following the date of service.

APPEAL PROCESS

If your claim is denied in whole or in part, Cigna will review its decision in accordance with the following procedure:

1. Within 180 days after receiving notice of a denial or partial denial, write Cigna at the above address stating the reasons why you do not agree with the decision.
2. You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you to an unauthorized representative.
3. After a written request for review has been received by Cigna, you or your authorized representative may, by appointment, ask to see pertinent documents and may submit written issues, comments, and additional information with 30 days after Cigna receives your request for review. Written notification of the final decision will be given 60 days after receipt of a request for review unless special circumstances require an extension of time for processing. In such an instance an additional 60 days will be allowed.

If you have any questions about the claims procedures or the review procedure, please contact Cigna or your Human Resources department.

RECOVERY OF OVERPAYMENTS

Occasionally, dental 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 dental 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 Plan member or dependent 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.

SPECIAL ELIGIBILITY PROVISIONS APPLICABLE TO HSHS ACQUISITIONS

For purposes of this section, *actively at work* means that a Colleague 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. A Colleague 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 a Colleague 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 Dental Insurance 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 Dental Insurance 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 Dental Insurance Plan Eligibility Requirements

If a business that HSHS acquires sponsors a group dental plan 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 Dental Insurance 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 Dental Insurance Plan's 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 Dental

Insurance Plan Continuation of Coverage for up to the lesser of:

(1) 18 months,

(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 Dental Insurance 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 Dental Insurance 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 Colleagues 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 Dental Insurance Plan's Continuation of Coverage provisions apply.

Individuals who enroll in the Dental Insurance 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 Dental Insurance 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 Colleagues 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 Dental Insurance Plan's Continuation of Coverage provisions apply.

Individuals who enroll in the Dental Insurance Plan under this provision may also enroll dependents that meet the dependent eligibility provisions of this Plan.

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 Dental Insurance 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 Colleagues of the HSHS Affiliate. Individuals who enroll in the Dental Insurance 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.

E. If the individual is a retiree of the acquired entity, the individual may **not** enroll in HSHS Dental Insurance 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 Dental Insurance 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 Colleagues 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 period expires, the HSHS Dental Insurance Plan's Continuation of Coverage provisions apply. Individuals who enroll in the Dental Insurance 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 Dental Insurance 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 Dental Insurance 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 the Dental Insurance Plan under this provision may also enroll any dependent that meets the dependent eligibility provisions of this Plan.

In all cases, coverage under the HSHS Dental Insurance 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 participant and the full premium payment must be received by the beginning of each pay period.

Please review the Plan's provisions with respect to replacement of missing teeth and treatment in progress for limitations that may apply. Benefits received under the *acquired entity's plan* do not apply to the HSHS Dental Insurance Plan's Yearly Maximum Benefit for all services or Lifetime Maximum for orthodontia services. Any out-of-pocket expenses incurred by an individual under the *acquired entity's plan* do not apply to the HSHS Dental Insurance Plan's annual deductibles.

GENERAL INFORMATION

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.

Name of Plan:
Flexplan Dental Insurance Plan

Plan Sponsor:
Hospital Sisters Health System

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

Group Number: 3214244

Participating Employers:

St. Elizabeth's Hospital (EIN-37-0663567)
One St. Elizabeth's Boulevard
O'Fallon, IL 62269
618-234-2120

St. Joseph's Hospital (EIN-37-1208459)
9515 Holy Cross Lane
Breese, IL 62230
618-526-4511

St. Mary's Hospital (EIN-37-0661244)
1800 East Lake Shore Drive
Decatur, IL 62521-3883
217-464-2966

St. Anthony's Memorial Hospital (EIN-37-0661233)
503 Maple Street
Effingham, IL 62401
217-342-2121

St. Joseph's Hospital (EIN-37-0663568)
12866 Troxler Ave
Highland, IL 62249
618-654-7421

St. Francis Hospital (EIN-37-0661236)
1215 Franciscan Drive
P.O. Box 1215
Litchfield, IL 62056-0999
217-324-2191

St. John's Hospital (EIN-37-0661238)
800 East Carpenter Street
Springfield, IL 62769
217-544-6464

Holy Family Hospital (EIN-37-0792770)
200 Health Care Drive
Greenville, IL 62246
618-664-1230

St. Joseph's Hospital (EIN-39-0810545)
2661 County Hwy I
Chippewa Falls, WI 54729-1498
715-723-1811

Sacred Heart Hospital (EIN-39-0807060)
900 West Clairemont
Eau Claire, WI 54701 715-839-4121

St. Mary's Hospital Medical Center (EIN-39-0818682)
1726 Shawano Avenue Green Bay, WI 54303
920-498-4200

St. Vincent Hospital (EIN-39-0817529)
835 S. Van Buren Street
Green Bay, WI 54307-3508
920-433-0111

St. Clare Memorial Hospital (EIN-39-0848401)
855 S. Main Street
Oconto Falls, WI 54154

St. Nicholas Hospital (EIN-39-0808480)
3100 Superior Avenue
Sheboygan, WI 53081
920-459-8300

HSHS Medical Group, Inc. (EIN-26-3956318)
P.O. Box 19456
Springfield, IL 62794-9456

HSHS Wisconsin Medical Group, Inc. (EIN-26-4515957)
P.O. Box 19456
Springfield, IL 62794-9456

Prairie Cardiovascular Consultants, Ltd. (EIN-37-1071858)
619 E. Mason Street
Springfield, IL 62701
217-788-0706

Prairie Education and Research Cooperative (EIN-37-1157915)
317 N. 5th Street
Springfield, IL 62701

Hospital Sisters Health System (EIN-37-1058692)
P.O. Box 19456 Springfield, IL 62794-9456
217-523-4747

NOTICE OF PRIVACY PRACTICES

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 AND DISCLOSURES FOR TREATMENT, PAYMENT, AND 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 with 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 Human Resource 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 your Human Resource 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 Human Resource 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 obtain a paper copy of this notice, contact your Human Resource Department.

To learn more about this procedure, or to make this request, you should contact your HR DEPARTMENT.

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 Page 1 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, in the top right-hand corner, 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.