



The benefits of choice

**Vision Insurance Plan
Summary Plan Description**

Effective January 1, 2018

TABLE OF CONTENTS

INTRODUCTION 1

ELIGIBILITY..... 2

ELIGIBLE COLLEAGUES 2

DEPENDENT ELIGIBILITY..... 3

ELIGIBILITY DETERMINATIONS ARE MADE BY PLAN ADMINISTRATOR 4

FAILURE TO ENROLL WHEN FIRST ELIGIBLE 4

ANNUAL ENROLLMENT..... 4

WHEN COVERAGE BEGINS..... 4

WHEN COVERAGE BEGINS FOR YOUR DEPENDENTS 5

THE COST OF YOUR COVERAGE..... 5

VISION COVERAGE LEVELS 5

CHANGING YOUR VISION PLAN COVERAGE 6

SPECIAL ENROLLMENT PERIODS 7

ANNUAL ENROLLMENT 8

TRANSFER POLICY 8

FAMILY LEAVE OR MEDICAL LEAVE 8

SPECIAL ELIGIBILITY PROVISIONS APPLICABLE TO ACQUISITIONS..... 9

TERMINATION OF COVERAGE 12

CONTINUATION OF COVERAGE..... 13

TERMINATION OF CONTINUATION OF COVERAGE 13

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994... 13

VISION COVERAGE..... 15

DEFINITIONS..... 16

NOTICE OF PRIVACY PRACTICES..... 19

IMPORTANT INFORMATION ABOUT THE PLAN..... 23

RIGHT TO AMEND OR TERMINATE THE PLAN..... 23

GENERAL PROVISIONS..... 23

IMPORTANT INFORMATION..... 23

PARTICIPATING EMPLOYERS: 23

INTRODUCTION

Many words used in this handbook have special meanings. These words begin with capital letters and are defined for you in the Definitions section. Refer to these definitions for the best understanding of what is being stated.

The Hospital Sisters Health System FlexPlan offers an insured vision option. See the Hospital Sisters Health System VSP Vision Booklet (VSP Vision Booklet) for the provisions of the vision option.

This summary plan description provides the introductory and administrative information that applies to the vision option. Covered Services, benefits, and exclusions are established by the Insurer and are subject to change. To determine the current list of Covered Services, benefits, prior authorization requirements, and exclusions for the vision option refer to the VSP Vision Booklet.

ELIGIBILITY

ELIGIBLE COLLEAGUES

To be eligible for coverage under this Plan, you must meet **all** of the following qualifications:

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
- 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. 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
- St. Clare Memorial Hospital
Oconto Falls, Wisconsin
- 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.

3. You are not a leased Colleague. Leased Colleagues are not eligible to participate in the Plan.

4. 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.

5. You are a medical resident on St. John's Hospital in Springfield, Illinois payroll.

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:

- a. 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.

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.

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.

DEPENDENT ELIGIBILITY

Your dependents eligible for coverage under the Plan include:

- a. 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.
- b. Each of your children up to the end of the month in which age 26 is attained.
- c. 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 Insurer.
- d. 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, 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. 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 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 or LDA 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 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. If you newly enroll a child, spouse or LDA 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.

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 not have vision coverage.

ANNUAL ENROLLMENT

You may change your vision election 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 vision coverage, 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.

THE COST OF YOUR COVERAGE

You will pay the full cost of coverage under the Plan. Your contributions for coverage will be deducted from your paycheck on a before-tax basis under Flexplan unless you are covering an LDA who is not a federal tax dependent. For an 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 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 FICA taxes, or state taxes in most states, on your insurance premium. 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 vision 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. 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.

VISION COVERAGE LEVELS

The Plan offers a four-tiered contribution structure for vision coverage:

- **Colleague Coverage:** Covers the Colleague only.

- **Colleague and Spouse/LDA:** Covers the Colleague and the Colleague's spouse or LDA
- **Colleague and Child(ren):** Covers the Colleague and all enrolled Dependent children of the Colleague
- **Family Coverage:** Covers the Colleague, the Colleague's spouse or LDA, and all enrolled Dependent children of the Colleague

CHANGING YOUR VISION 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/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 that meets the requirements specified in the *Dependent Eligibility* section.
- **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 vision eligibility.
- **Your child satisfies or ceases to satisfy the Dependent Eligibility requirements** specified in the Dependent Eligibility section.
- **Change in other vision coverage as a result of your spouse’s or LDA’s employer’s annual enrollment** - If you and/or your Dependents become covered by or lose coverage through another vision 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 vision coverage accordingly. However, your election to change your coverage must be made within 30 days of when your spouse’s or LDA’s vision coverage change becomes effective.
- **Change in other vision 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 vision 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 vision coverage accordingly. However, your election to change your coverage must be made within 30 days of when your eligible child’s vision coverage change becomes effective.
- **Significant change in the cost of vision 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 vision coverage available** through your spouse's or LDA's employer, eligible child's employer, or employer of your eligible child's spouse.

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 vision coverage under this Plan or a vision plan of another employer (this includes becoming eligible or ineligible for a particular benefit package 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 vision plan of another employer **and** the election change corresponds with that change in cost.

To change your vision insurance election due to a status change, complete and submit the necessary forms to the HSHS Colleague Service Center within 30 days of the date of the status change. If you newly enroll a child, spouse or LDA, 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 vision 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 vision 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.

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

The following rules apply to changing your vision coverage during annual enrollment:

- a. You may add or drop coverage for yourself or your Dependents during the annual enrollment period. If you newly enroll a child, spouse or LDA, you must provide documentation of their relationship to you.
- b. If you are currently enrolled and do not actively enroll or waive coverage during open enrollment, your coverage at the current coverage level [Colleague only, Colleague + Child(ren), Colleague + Spouse/LDA, or Colleague + Spouse/LDA + Child(ren)] will continue at the new year's premium amount.

Changes made during the annual enrollment period generally 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.

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 for a limited time 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 family or medical leave of absence.

A Colleague taking an approved medical leave of absence for his/her own serious health condition will pay the full cost premium amount of vision 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 full premium amount for vision 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 general leave of absence, in accordance with the Plan Sponsor's policy on general leaves of absence, coverage with terminate at midnight on the day before the general leave of absence begins. Colleagues may continue coverage under the Plan's *Continuation of Coverage* provisions.

SPECIAL ELIGIBILITY PROVISIONS APPLICABLE TO 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 Vision 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 vision insurance 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 vision plan that provides vision 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 vision insurance:

- 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 the HSHS Vision 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 the HSHS Vision 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 Vision 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 the HSHS Vision 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 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 Vision Plan *Continuation of Coverage* provisions apply.

Individuals who enroll in the HSHS Vision 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 the HSHS Vision 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 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 Vision Plan's *Continuation of Coverage* provisions apply.

Individuals who enroll in the HSHS Vision 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 the HSHS Vision 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 amount that applies to active employees of the HSHS Affiliate. Individuals who enroll in the HSHS Vision 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, the individual may enroll in the HSHS Vision 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. An early retiree that enrolls in the HSHS Vision 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, the individual may **not** enroll in the HSHS Vision 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 the HSHS Vision 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 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 Vision 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 Vision 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 Vision 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 HSHS Vision 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.

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 have been paid.

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

- The date your spouse or LDA 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, LDA 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 premiums paid by

the Plan for coverage 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 Vision 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). The Colleague may also elect Continuation Coverage for any Dependent covered under this Plan at the time of his/her coverage termination.
2. The former spouse of a Colleague whose coverage would otherwise cease due to divorce or annulment.
3. The spouse or Dependent child 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 or until age 65, whichever comes 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 who 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 vision 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 your military service protected by the Act, you must pay 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.

VISION COVERAGE

The current list of Covered Services, benefits and exclusions for the vision coverage are provided in the Hospital Sisters Health System VSP Vision Booklet. This booklet also provides the plan administration provisions for the vision coverage, including claim payment and denial procedures.

DEFINITIONS

The following terms shall have the meanings described for purposes of this Summary Plan Description.

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.

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

Business Associate means those entities that provide services to the Plan who may receive Protected Health Information in order to perform services for the Plan.

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

Covered Person: a Subscriber or Dependent who has satisfied the Plan's eligibility conditions, is enrolled in coverage and on whose behalf premiums have been paid to VSP.

Covered Services is as defined in the HSHS VSP Vision Booklet of the Plan.

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.

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

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

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

Insurer shall mean the person or entity providing administrative services to the Plan in connection with the processing and payment of claims. The Insurer is Vision Service Plan.

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.

Network Provider: a Provider who has entered into a contractual agreement or is otherwise engaged by the Insurer, or with another organization which has an agreement with the Insurer, regarding Plan payments. For purposes of the HSHS Vision Plan, Network Providers includes Prevea providers who perform services that are considered Covered Services under the Plan.

Non-Network Provider: a Provider that is not a Network Provider.

Plan: the HSHS Vision Plan.

Plan Administrator: Hospital Sisters Health System.

Plan Sponsor: Hospital Sisters Health System.

Protected Health Information means confidential health information that identifies a Covered Person or could be used to identify a Covered Person and relates to a physical or mental health condition or the payment of health care expenses.

Provider is as defined in the VSP Vision Booklet.

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.

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.

Summary Plan Description (SPD): with respect to the HSHS Vision Plan, this document, and the VSP Vision Booklet.

NOTICE OF PRIVACY PRACTICES

Effective 01/01/2018

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”) vision 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 vision care which are received by the HSHS Plan.

Your vision Treatment providers 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 Human Resources 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 Human Resources 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 Resources 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 Human Resources 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 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.

IMPORTANT INFORMATION ABOUT THE PLAN

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.

GENERAL PROVISIONS

The Insurer has the sole and absolute discretion and authority to interpret the terms of the Plan, resolve ambiguities and inconsistencies in the Plan, and make all decisions regarding entitlement to the Plan's vision benefits.

The Plan has the right to recover any excess payments or benefits that were not paid in accordance with Plan terms.

A Covered Person always has the choice of what services they receive and who provides their vision care, regardless of what the Plan covers or pays. The Plan does not provide or ensure the quality of care received. The Insurer, or their designee, has contracted with vision care professionals to participate in their networks. Neither the Plan nor HSHS hold a contract with these professionals for purposes of this Plan.

IMPORTANT INFORMATION

Name of Plan:

HSHS Vision Plan

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
O'Fallon, Illinois
- St. Joseph's Hospital
Breese, Illinois
- St. Mary's Hospital
Decatur, Illinois
- Sacred Heart Hospital
Eau Claire, Wisconsin
- St. Mary's Hospital Medical Center
Green Bay, Wisconsin
- St. Vincent Hospital
Green Bay, Wisconsin

- 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
- 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
- St. Clare Hospital
Oconto Falls, Wisconsin
- Prairie Education & Research Cooperative
Springfield, Illinois

This summary describes the document that governs the HSHS Vision Plan. Every effort has been made to accurately describe the Plan in this summary. However, if there should be a discrepancy between this summary and the formal Plan document - or if the Plan is required to operate in a different manner to comply with federal laws and regulations - the Plan document, and the appropriate federal laws and regulations, will control.