FLEXPLAN

The benefits of choice

Hospital Sisters Health System Flexplan Summary Plan Description

Effective January 1, 2018

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INTRODUCTION

Hospital Sisters Health System ("HSHS") is pleased to sponsor the HSHS Flexplan (the "Plan") to provide you the flexibility to choose the benefit options that best suit your needs and enable you to pay for certain benefits on a pre-tax basis. The Plan has two primary parts: pre-tax payment of medical, dental, vision, and voluntary accidental death and dismemberment ("Voluntary AD&D") insurance premiums and flexible spending accounts for health and dependent care expenses.

This summary is intended to provide an explanation of how the Plan operates. Every effort has been made to make these explanations as accurate as possible. If any discrepancies are found between this summary and the provisions of the Plan, or if any provision is not covered or is only partially covered, then the terms of the actual Plan will govern.

Many words used in this document 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.

Take a few minutes to carefully read this summary. If you have any questions, please contact the Plan Administrator.

ELIGIBILITY AND PARTICIPATION

ELIGIBLE COLLEAGUES

To be eligible for pre-tax medical, dental, vision and voluntary AD&D premium options or to participate in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, 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 painter employed by St. John's Hospital in Springfield, Illinois who is a member of a collective bargaining unit. 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.

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.

ELIGIBILITY FOR DAS EMPLOYEES

As of August 1, 2018, employees of Decatur Ambulance Service that meet the eligibility requirements of the Teamsters and Employers Welfare Trust of Illinois Health Care Benefit Program are eligible to contribute on a pre-tax basis for benefits offered through the Teamsters and Employers Welfare Trust of Illinois Health Care Benefit Program and the AFLAC cancer, specified health conditions, dental and vision benefits offered.

COVERAGE UPON REHIRE

If you terminate employment after becoming eligible for Flexplan benefits and you are rehired within 90 days, you can participate in Flexplan benefits on your rehire date. If you are rehired within 30 days of your termination date, your prior Flexplan elections will be re-instated. If you experienced a change in status, change in coverage or change in cost during the period you were not in Active Employment, you may enroll in any of the benefits for which you are eligible.

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.

INITIAL ENROLLMENT

You must complete your Flexplan enrollment by the enrollment deadline that is stated in the enrollment instructions provided to you in order for your coverage to become effective. If you do not make an election by the enrollment deadline, the enrollment instructions will specify the coverage, if any, that will apply to you. If you experience a change in status, change in

coverage or change in cost during the Plan Year as described in ***Changing your Flexplan Coverage***, you may be able to enroll or change your benefit elections. Enrollment in a HSHS-sponsored medical, dental, vision or voluntary AD&D plan is considered an election to participate in this Plan for purposes of your premium payments for those plans, once you have met this Plan's eligibility requirements.

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, change in coverage or change in cost as described in ***Changing Your Flexplan Coverage***.

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.

ANNUAL ENROLLMENT

You may change your coverage elections during annual enrollment each 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. Changes made during the annual enrollment period generally become effective on the following January 1. Once you enroll in the plan and elect to pay your share of the cost with before-tax dollars, you cannot change this enrollment decision until the next enrollment period unless you have a change in status, change in coverage or change in cost. See "***Changing Your Flexplan Coverage***" for more information. Enrollment in a HSHS-sponsored medical, dental, vision or voluntary AD&D plan is considered an election to participate in this Plan for purposes of your premium payments for those plans, once you have met this Plan's eligibility requirements.

BENEFITS AVAILABLE UNDER THE PLAN

If you have met all the eligibility qualifications:

- of the HSHS Healthy Plan and have elected medical coverage under that plan, your portion of the premium for those coverages will be withheld on a pre-tax basis,
- of the Dental Insurance Plan and have elected dental coverage under that plan, your portion of the premium for those coverages will be withheld on a pre-tax basis,
- of the Vision Insurance Plan and have elected vision coverage under that plan, your portion of the premium for those coverages will be withheld on a pre-tax basis,
- of the Voluntary Accidental Death and Dismemberment Insurance Plan and have elected coverage under that plan, your portion of the premium for those coverages will be withheld on a pre-tax basis,
- you can elect to establish a Health Care Flexible Spending Account to use pre-tax dollars to pay for certain expenses not covered by your medical, dental and vision plans or any other health and dental coverage you may have; and
- you can elect to establish a Dependent Care Flexible Spending Account to use pre-tax

dollars to pay for certain dependent and child care expenses.

If you are a medical resident on St. John's Hospital in Springfield, Illinois payroll, have met the eligibility requirement of the medical, dental, vision and/or voluntary AD&D plans offered to you and elected coverage under one or more of these plans, your portion of the premium for the coverage will be withheld on a pre-tax basis.

CHANGING YOUR FLEXPLAN 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", "change in coverage" or "change in cost".

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 each 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 each Plan′s dependent eligibility requirements.
- **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 each Plan's eligibility.
- **Your child satisfies or ceases to meet each Plan′s dependent eligibility requirements**
- **Your spouse, your eligible child or your eligible child's spouse moves to an area where he/she is outside the service area for his/her employer's plan**, you may add yourself, your spouse and/or any eligible children previously covered under that plan to the same type of coverage under Flexplan.
- **Change in other 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 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 coverage accordingly. However, your election to change your coverage must be made within 30 days of when your spouse's or LDA's coverage change becomes effective.
- **Change in other 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 each Plan's dependent eligibility requirements becomes covered by or loses coverage through another 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 coverage accordingly. However, your election to change your coverage must be made within 30 days of when your eligible child's coverage change becomes effective.

- **Occurrence of certain events** under the Health Insurance Portability and Accountability Act (HIPAA) or the Family and Medical Leave Act (FMLA) (contact the HSHS Colleague Service Center for more information).
- **Significant change in the cost of 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 coverage available** through your spouse's or LDA's employer, eligible child's employer, or employer of your eligible child's spouse.
- **Change in day care providers, the hours for which care is needed, or the cost of day care.**

Change in coverage includes the addition of a new benefit option, the elimination of an existing benefit option or a significant change in an existing benefit under this Plan and a change in your coverage or that of your spouse, LDA or eligible child through your spouse's or LDA's employment, your eligible child's employment or eligible child's spouse's employment, including those changes resulting from an election during an annual enrollment period for another employer's plan that differs from this Plan's.

Change in cost means an increase or decrease in your cost for a benefit during a Plan Year. For purposes of the Dependent Care Flexible Spending Account, a change in the amount charged for dependent care is considered a change in cost. For purposes of a medical, dental, vision plan, or voluntary AD&D, a significant change in the cost of your or your eligible dependent's coverage through your spouse's or LDA's employment, your eligible child's employment, or the employment of your eligible child's spouse is considered a change in cost.

If a change in status, change in coverage or change in cost 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 coverage under this Plan or a 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 plan of another employer and the election change corresponds with that change in cost.

To change your election due to one of the above circumstances, 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.

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.

CONTRIBUTIONS

One of the most attractive features of your Flexplan is that you pay your portion of any premiums for medical, dental, vision, and voluntary AD&D coverage on a before-tax basis. It also enables you to contribute on a before-tax basis to a Health Care Flexible Spending Account and a Dependent Care Flexible Spending Account.

When you pay for benefits with before-tax dollars, it means that your share of premiums is paid before the following taxes are taken out of your pay:

- federal income taxes,
- Social Security taxes, and
- state income taxes (in most states)

Since your premiums are taken out of your pay first, your taxable income will be lower, and you will pay less in taxes.

Paying your premiums with before-tax dollars will not affect other HSHS benefits that are based on your total annual pay, such as your retirement plan, life insurance, and 403(b) plan.

However, government-sponsored benefits such as Social Security may be affected. If your annual earnings are lower than the Social Security taxable wage base, you will pay less in Social Security taxes because your taxable income will be reduced by the amounts you pay with before-tax dollars, and the Social Security benefits received at retirement may be slightly less. For most employees, however, the immediate tax benefits of pre-tax contributions outweigh the slightly reduced future Social Security benefit.

It is important to point out that your tax savings will vary depending on your family status, annual earnings, the number of exemptions and deductions you claim on your tax return, your tax bracket and local tax regulations. Additionally, for dependent care expenses, there is also a dependent care tax credit. For some people, the tax credit may provide greater tax savings than the Dependent Care Flexible Spending Account.

MAXIMUM CONTRIBUTION

Health Care Flexible Spending Account

You can set aside up to $2,650 per year in before-tax dollars into a Health Care Flexible Spending Account. The minimum contribution to participate is $5 per pay period. Your coverage under the account shall be equal to the pay period contribution you elect, multiplied by the number of pay periods your contribution is in effect during the Plan Year.

Dependent Care Flexible Spending Account

The amount that you can contribute in before-tax dollars into a Dependent Care Flexible Spending Account depends on your marital status and how you file taxes. The IRS limits the total any one family can contribute to a Dependent Care Flexible Spending Account to $5,000 per year. The minimum contribution to participate is $5 per pay period. If you are married

and do not file a joint tax return with your spouse, the most you can contribute to the Dependent Care Flexible Spending Account is $2,500 per year.

Per IRS rules, contributions to the Dependent Care Flexible Spending Account cannot exceed the lesser of your annual earnings or those of your spouse. If your spouse is disabled or a full-time student, the law specifies minimum amounts that your spouse is considered to have earned. See IRS Publication 503 or contact the HSHS Colleague Service Center for more information.

MAXIMUM ALLOWED PRE-TAX CONTRIBUTION

If you meet the eligibility requirements, your maximum allowable pre-tax contribution is the sum of:

- the highest employee contribution amount required to participate in any of the medical options available to you under the terms of the HSHS Healthy Plan;
- the highest employee contribution amount required to participate in any of the dental options available to you under the terms of the Dental Insurance Plan;
- the highest employee contribution amount required to participate in any of the vision options available to you under the terms of the Vision Insurance Plan;
- the highest employee contribution amount required to participate in any of the AD&D options available to you under the terms of the Voluntary AD&D Insurance Plan;
- the Health Care Flexible Spending Account maximum contribution amount specified in that section; and
- the Dependent Care Flexible Spending Account maximum contribution amount specified in that section.

TERMINATION OF COVERAGE

Your participation in the pre-tax medical, dental, vision and voluntary AD&D premium, Health Care Flexible Spending Account and Dependent Care Flexible Spending Account components of this Plan ends 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;
- Thirty days after you begin active duty in the Armed Forces of any country, however, you can continue coverage under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). For information regarding your ability to continue coverage under USERRA, refer to ***Coverage During Leaves of Absence***;
- On the date ending the period for which contributions have been paid.

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.

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

CONTINUATION OF COVERAGE

Continuation of coverage is not provided for the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account if your coverage is terminated. Refer to the HSHS Healthy Plan, HSHS Dental Insurance Plan, or HSHS Vision Insurance Plan Summary Plan Descriptions for information about continuation of coverage for these options.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

Your Health Care Flexible Spending Account (Health Care FSA) is designed to add to the coverage you already have through your medical, dental and vision insurance plans. Plus, it can help you pay for some expenses that aren't covered at all. Here's how it works:

- Money is deducted from your pay check and placed into your account before taxes are taken out, and
- You pay for health care expenses out of your pocket, as usual, and
- You file a claim to pay yourself back for eligible health care expenses not paid by your medical, dental or vision insurance plans or by any other group coverage. Alternatively, you can use your debit card to pay expenses and receive reimbursements as outlined in ***Filing Claims Under the Flexible Spending Accounts***.

ELIGIBLE HEALTH CARE EXPENSES

Eligible health care expenses are determined by the Internal Revenue Service (IRS) and must be incurred during the coverage period. The coverage period is usually January 1 through December 31, but will end sooner if you cease participation in the Plan (including if you stop contributing to the Health Care FSA) and start later if you join the Plan after January 1 or elect to participate in the Health Care Flexible Spending Account after January 1 due to a change in status or change in coverage as outlined in ***Changing Your Flexplan Coverage***.

The lists below outline some of the expenses that are eligible – or not eligible – to be reimbursed through a Health Care FSA. **NOTE: For ethical and philosophical reasons, abortions, sterilizations, contraceptives, sexual reassignment, in-vitro fertilization, artificial insemination, and embryonic implantation procedures will not be allowed as reimbursable expenses.**

Some eligible health care expenses include:

- Diagnosis and therapy: insulin, laboratory tests, medical and dental exams, physical therapy, whirlpool treatments and X-rays;
- Health care aids: braces and other orthodontic devices, contact lenses, crutches, dentures, glasses, guide dogs and their maintenance, hearing aids (including batteries), and wheelchairs;
- Health care provider fees: acupuncturists, chiropractors, Christian Science practitioners, dentists, medical doctors, ophthalmologists, optometrists, osteopaths, podiatrists, psychiatrists, psychoanalysts, psychologists, physical therapists and radiologists;
- Hospital care: clinics, emergency care, inpatient care, laboratory, outpatient care, therapies and X-rays;
- Insurance: coinsurance, copayments and deductibles;
- Medications: drugs, medicine, vaccines and vitamins that require a prescription and are prescribed by your physician;
- Nursing services: home health care, hospice, nursing care, visiting nurses;

- Other: medical treatment/medication for drug addiction, alcoholism and smoking cessation programs; and
- Required travel: ambulance service, taxi service, and other travel costs to get medical care.

Health care expenses that are not eligible under the Health Care FSA include:

- Expenses which have been or will be reimbursed from insurance or other sources;
- Insurance premiums;
- Long-term care expenses;
- Illegal care, operations, drugs or therapy;
- Travel your doctor prescribed for rest or change;
- Over-the-counter medications, drugs, vaccines and vitamins;
- Weight control programs, meals, diaper service, health club dues, household help, custodial care in an institution, marriage or family counseling or funeral expenses;
- **Abortions, sterilizations, contraceptives, sexual reassignment, in-vitro fertilization, artificial insemination, or embryonic implantation procedures due to HSHS ethics/philosophy;**
- Cosmetic surgery, drugs for cosmetic purposes, electrolysis (even if performed by a licensed technician) and hair transplants (even if performed by a physician);
- Meals;
- Teeth bleaching and sonic toothbrushes; and
- Physicals for employment and flight physicals.

This is only a partial listing of qualified expenses. A complete listing may be obtained from Tri-Star by calling 1-800-727-0182 or by visiting their website www.tri-starsystems.com. You may also see Internal Revenue Service Publication 502 – except:

- expenses don't have to exceed 7.5% of adjusted gross income to be reimbursed from the Health Care Flexible Spending Account; and
- insurance premiums and long-term care expenses cannot be reimbursed from the Health Care Flexible Spending Account.

Your eligible health care expenses and those of the following individuals may be reimbursed from the Health Care Flexible Spending Account:

- your legal spouse;
- your child up to age 26;

A "child" is your natural born child, stepchild, legally adopted child, child who is being adopted and is still within the adoption process, and a child for whom you are the legal guardian. A foster child can be considered a dependent when the adoption process is in progress. Coverage is also extended to a child of your child (your grandchild) for whom you have assumed responsibility. The grandchild must live in your home and be principally

dependent on you for support and maintenance. When the grandchild's parent (your child) reaches the Plan's limiting age, eligibility for the grandchild ceases.

If the Plan Administrator receives a qualified medical child support order (QMCSO) relating to the Health Care Flexible Spending Account, the Health Care Flexible Spending Account will provide the health benefit coverage specified in the order to the person or persons ("alternate recipients") named in the order to the extent the QMCSO does not require coverage the Health Care Flexible Spending Account does not otherwise provide. "Alternate recipients" include any child of the participating Colleague who the Plan is required to cover pursuant to a QMCSO. A "medical child support order" is a legal judgment, decree or order relating to medical child support. A medical child support order is a QMCSO to the extent it satisfies certain conditions required by law. Before providing any coverage to an alternate recipient, the Plan Administrator must determine whether the medical child support order is a QMCSO. If the Plan Administrator receives a medical child support order relating to your Health Care Flexible Spending Account, it will notify you in writing, and after receiving the order, it will inform you of its determination of whether or not the order is qualified. Upon request to the Plan Administrator, you may obtain, without charge, a copy of the Plan's procedures governing qualified medical child support orders.

ALSO, if you change your Health Care Flexible Spending Account election as the result of a change in status or change in coverage as described in ***Changing Your Flexplan Coverage***, the coverage amount prior to the change will be unaffected. The coverage amount from the date of the election change through the end of the coverage period will be calculated by adding:

- the premium contribution in effect prior to the election change multiplied by the number of pay periods during that period, and
- the premium contribution in effect following the election change multiplied by the number of applicable pay periods remaining in the coverage period.

In the event you change your Health Care Flexible Spending Account contribution election to zero, your coverage will cease as of the day your election is effective. Expenses incurred after your contribution is changed to zero will not be eligible for reimbursement.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

ELIGIBLE DEPENDENTS

You can use the Dependent Care Flexible Spending Account (Dependent Care FSA) to help pay yourself back with pre-tax dollars for the cost of eligible day care for your dependents while you work. If you are married, the care must be needed so you and your spouse can work. Your eligible dependents are:

- Children under age 13 who will live with you for more than half of the year and will not provide over half of their own support.
- Anyone physically or mentally incapable of caring for himself or herself who will live with you for more than half of the year, will regularly spend at least 8 hours each day in your home, and for whom you will provide over half the support in the year, such as an elderly parent or a disabled spouse or dependent who is incapable of self-care.

WHO MAY BE REIMBURSED

According to the IRS, you may be reimbursed for expenses for the care of your eligible dependents while you work or, if married, while you and your spouse work if:

- you are single with an eligible dependent, or
- you are married and your spouse is:
  - a wage earner, or
  - a full-time student for at least five months during the year, or
  - disabled and unable to provide for his or her own care.

You can be reimbursed for dependent care which is provided by someone other than your spouse, a dependent on your income tax return or one of your or your spouse's children under age 19. However, if care is provided outside your home at a facility that provides care for more than six (6) individuals who do not regularly reside at the facility, the facility must comply with all state and local laws and regulations.

You must present detailed receipts from your caregiver which includes such information as the dependent's name and age, and the caregiver's Taxpayer Identification number. For a complete list of required information, contact Tri-Star at 1-800-727-0182 or www.tri-starsystems.com.

Under IRS rules, to be reimbursed through your account, day care must be provided by a person you can give a Social Security number for or a day care facility with a Taxpayer Identification number. Day care provided by any sitter whom you or your spouse claims as a dependent on your tax return cannot be reimbursed through your account. This includes day care services provided by your children or stepchildren under age 19. In addition, day care provided by your spouse or former spouse is not eligible for reimbursement.

ELIGIBLE DEPENDENT CARE EXPENSES

The lists below outline some of the expenses that are eligible – or not eligible – to be reimbursed through a Dependent Care FSA. For a complete listing of eligible expenses, contact the HSHS Colleague Service Center or see IRS Publication 503, Child and Dependent Care Expenses.

Some eligible dependent care expenses include:

- Wages paid to a babysitter, unless you or your spouse claims the sitter as a dependent. Care can be provided in, or outside of, your home;
- Services of a dependent care center (such as a day care center or nursery school). If the facility provides care for more than six individuals (other than those who reside there), and receives a fee, payment or grant for providing its services, it must comply with all applicable state and local laws and regulations;
- Cost for adult care at facilities away from home, such as family day care centers, as long as your dependent spends at least eight hours at home. If the facility provides care for more than six individuals (other than those who reside there) and receives a fee, payment or grant for providing its services, it must comply with all applicable state and local laws and regulations; and
- Wages paid to a housekeeper for providing care to an eligible dependent. Household services, including the cost to perform ordinary services needed to run your home which are at least partly for the care of a qualifying individual, are covered as long as the person providing the services is not your dependent under age 19 or anyone you or your spouse claim as a dependent for tax purposes.

Expenses that are not eligible under the Dependent Care FSA include:

- Amounts you pay to an immediate family member under the age of 19 or any person you claim as a dependent on your federal income tax return;
- Expenses for dependent care when you or your spouse is not working;
- Transportation expenses for a care provider to come to your home;
- Child support payments;
- Education expenses for kindergarten and above;
- All overnight camp expenses;
- Other camp expenses, except summer day camps outside of the school year;
- Food, clothing and entertainment;
- Cleaning and cooking services not provided by the care provider; and
- Amounts you claim as a dependent care tax credit.

In addition, you cannot use your Dependent Care FSA to reimburse yourself for services that:

- Allow you to participate in leisure-time activities;
- Allow you to attend school part time;

- Enable you to attend educational programs, meetings or seminars; or
- Are primarily medical in nature (such as in-house nursing care).

How Much You Can Set Aside

If single or married and filing joint tax return: Up to $5,000

If married and filing joint tax return and your spouse's employer offers a dependent care account: Up to $5,000 between both accounts

If married and filing separate tax returns: Up to $2,500

The minimum contribution to participate is $5 per pay period.

If you and your spouse are divorced and you have custody of your child(ren), you may be able to be reimbursed from the Dependent Care Flexible Spending Account even if you do not claim the dependent on your federal income tax return. See IRS Publication 503 for more information.

Income Tax Reporting

The IRS requires that:

- HSHS report on your W-2 statement any pre-tax amounts redirected from your salary to the Dependent Care Flexible Spending Account; and
- you must file the name, address and taxpayer I.D. number of your dependent care provider(s) with your federal tax returns.

The IRS also makes available a tax credit for dependent care expenses. You cannot take advantage of both the Dependent Care Flexible Spending Account and the tax credit for the same expense. You should consult your tax counsel for advice on which is better for you.

FILING CLAIMS UNDER THE FLEXIBLE SPENDING ACCOUNTS

If you are enrolled in the Health Care Flexible Spending Account or Dependent Care Flexible Spending Account, you may submit a request to the Claims Administrator to be reimbursed for eligible expenses.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT

If you have an eligible health care expense that is covered by the HSHS Healthy Plan, Dental Insurance Plan, Vision Insurance Plan or another medical, dental or vision plan, you should first submit it for payment under that plan. For any eligible health care expenses not covered by one of these plans, you can submit a claim for reimbursement using one of the following options.

- You can use Tri-Star's website (www.tri-starsystems.com)
- You can use the Benny Card. You must retain the receipt for one year following the close of the Plan Year in which the expense is incurred. Even though payment is made using the Benny Card, a receipt may be required to be submitted. The Claims Administrator will notify you requesting documentation. You must provide the documentation within the timeframe specified in the request.
- You can get a claim form online at benefits.hshs.org. The claim form will include a list of the information needed to submit the claim, such as an itemized statement, explanation of benefits, etc.

The claim will be processed as soon as administratively possible. If the expense is determined to not be an eligible health care expense, you will receive notification of this determination. You must pay back any improperly paid claims. If you are unable to provide adequate or timely written documentation as requested, you must repay the Plan for the unsubstantiated expense. In addition, your usage of the card may be terminated by the Plan.

The full annual Health Care Flexible Spending Account coverage amount elected will be available at all times during the coverage period, less previous reimbursements, and subject to adjustment if you change your election before the end of a Plan Year.

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT

If you have an eligible dependent care expense, you can submit a claim for reimbursement using one of the following options.

- You can use Tri-Star's website (www.tri-starsystems.com)
- You can get a claim form online at benefits.hshs.org

Dependent care expenses will only be reimbursed up to the amount you have available in your account. Expenses submitted in excess of your account balance will be held and paid as additional contributions are made to your account.

SUBMITTING CLAIMS

- Health Care FSA Expenses - You must submit expenses no later than May 1 following the end of the Plan Year for expenses incurred during the Plan Year or through March 15th following the Plan Year
- Dependent Care FSA Expenses - You must submit expenses no later than May 1 following the end of the Plan Year for expenses incurred during the Plan Year.

If your employment ends, only expenses for services received through your benefit end date are eligible for reimbursement. The benefit end date is the last day of the pay period in which a Colleague's employment is terminated.

Each time you submit a claim, you will receive information about the status of your account. You will also receive a detailed statement of your account 90 days before the end of the year. Reimbursements from your account(s) are directly deposited to your designated bank account on the Monday following submissions received by the preceding Friday. Direct deposit is required. You will receive an explanation of payment via email. You are required to keep a valid, working email address on file with the Claims Administrator.

FILING AN APPEAL

You have the right to appeal any claim that has been denied for any reason. If a claim has been denied, you have 180 days from the denial to file an appeal. To file the appeal you must send a letter to:

Tri-Star Systems
ATTN: Claims Appeal
14323 South Outer 40 Road, Suite 200 South
Chesterfield, MO 63017

In your letter, please provide your name, the claim being appealed, and any information you can provide on why you think the claim should be approved. Your appeal will be reviewed by a supervisor who is different from and not subordinate to the claims processor who originally denied the claim.

If the claim remains denied after the appeal, you will receive written notification of the reason for the denial and the plan provisions on which the determination is based. You may request and receive relevant documents and other information pertaining to the review. In addition, you will also be notified of your right to sue if your claim is denied.

USE IT OR LOSE IT

If you have money left over in your Health Care FSA at the end of the calendar year, you can use your remaining balance for expenses incurred up through March 15 of the following year. You have until May 1 of the following year to file a fully qualified Health Care FSA claim with proper and complete documentation.

For the Dependent Care FSA, you have until May 1 of the following year to file a fully qualified claim with proper documentation for expenses incurred during the calendar year.

Any amounts left in your accounts will be forfeited and used to offset administrative expenses of the Plan. In the event that forfeitures exceed administrative expenses, those funds may be

used to offset losses experienced from reimbursements exceeding plan contributions of other participants, reduce required salary reductions for the next plan year on a reasonable and uniform basis, returned to employees on a reasonable and uniform basis, or, in the discretion of the Employer, any other use permitted by applicable law.

NO COMMINGLED ACCOUNTS

Your Health Care and Dependent Care FSAs are separate accounts. You can't use funds from your Health Care FSA to pay for dependent care expenses or vice versa.

Excess Reimbursements

If, as of the end of any Plan Year, it is determined that you have received payments that exceed the amount of qualified expenses that have been properly substantiated during the Plan Year or reimbursements have been made in error (e.g. reimbursements were made for expenses incurred for the care of an individual who was not a qualifying individual), the Claims Administrator may recoup excess reimbursements in one or more of the following ways:

a. The Claims Administrator will notify you of any such excess amount, and you will be required to repay the excess amount to the Employer within sixty days of receipt of such notification;

b. The Claims Administrator may offset the excess reimbursment against any other qualified expense submitted for reimbursement (regardless of the Plan Year in which submitted); and/or

c. The Employer may withhold such amounts from your pay (to the extent permitted under applicable law)

COVERAGE DURING LEAVES OF ABSENCE

MEDICAL, DENTAL, VISION AND VOLUNTARY AD&D BENEFITS WHILE ON LEAVE OF ABSENCE

Your ability to continue coverage under the medical, dental, vision or voluntary AD&D benefits offered under this Plan while you are on an approved leave of absence, including a leave of absence under the Family and Medical Leave Act or a military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), is governed by the terms of each benefits summary plan description.

HEALTH CARE FLEXIBLE SPENDING ACCOUNT WHILE ON LEAVE OF ABSENCE

If you take a family leave or medical leave of absence during the year, you may continue making contributions to your Health Care FSA while on leave, or you may stop making contributions. If you want to continue making Health Care FSA contributions and you are on a paid leave, your contributions will continue to be deducted, before taxes, from your pay. You may choose among three payment options for Health Care FSA contributions during an unpaid family leave or medical leave of absence:

- You may pre-pay through payroll deductions prior to your leave.
- You may remit payment while you are on leave. In this case, the first payment is due no later than 30 days following the date of your last payroll deduction. Payments are due monthly thereafter. Under this option, payments are after tax.

If you stop making contributions, you will forfeit your account balance.

If you are on an unpaid approved general leave of absence, in accordance with the Plan Sponsor's policy on general leaves of absence, your Health Care FSA coverage will terminate at the beginning of your general leave. Any balance as of the beginning of your general leave will be forfeited.

If you take military leave under the Uniformed Services Employment and Reemployment Rights Act (USERRA), you may continue your coverage for up to 24 months provided that you give HSHS advance notice of the leave (with certain exceptions), and your total leave, when added to any prior periods of military leave from HSHS, does not exceed five years (with certain exceptions).

DEPENDENT CARE FLEXIBLE SPENDING ACCOUNT WHILE ON LEAVE OF ABSENCE

Contributions to the Dependent Care FSA cease while you are on leave (this includes family leave, medical leave and other leaves, including military leaves), regardless of whether the leave is paid or unpaid. Your balance is forfeited when your leave begins.

EXPENSE ACCOUNTS WHEN YOU RETURN FROM A LEAVE OF ABSENCE

If your Health Care FSA coverage ends because you fail to make timely payments during a leave of absence:

- If you are on a leave of absence for more than 30 days, you will be eligible to re-enroll immediately upon returning from your leave.

- If you are on a leave of absence for 30 days or less, unless you experience a change in status, change in coverage or change in cost or an open enrollment period occurs while you are on leave, your Health Care FSA contribution will automatically be reinstated on the day you return from leave, at the same amount as was in effect prior to your leave.

With respect to the Dependent Care FSA when you return from a leave of absence:

- If you are on a leave of absence for more than 30 days, you will be eligible to re-enroll immediately upon return from your leave.
- If you are on leave of absence for 30 days or less, unless you experience a change of status or an open enrollment period occurs while you are on leave, your Dependent Care FSA contributions will automatically be reinstated on the day you return from leave at the same amount as was in effect prior to your leave.

DEFINITIONS

The following terms shall have the meanings described for purposes of this document.

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 and Participation*** 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.

Claims Administrator means the person or entity providing day-to-day administrative services to the Plan in connection with the processing and payment of claims. The Claims Administrator is identified in the ***Important Information About Your Flexplan*** section.

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.

Dependent: a person of the Subscriber's family who is eligible for coverage under the Plan according to the provisions outlined in each plan's summary plan description.

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

Flexplan: the HSHS employee benefit program that allows Colleagues to pay their cost of coverage with pre-tax contributions and participate in Health Care and Dependent Care Flexible Spending Accounts.

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.

Plan: the HSHS Flexplan.

Plan Administrator: Hospital Sisters Health System.

Plan Sponsor: Hospital Sisters Health System.

Plan Year means the one-year period beginning on January 1 and ending December 31.

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.

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.

GRANDFATHERED HEALTH PLAN NOTICE

The Flexplan believes the Health Care Flexible Spending Account plan is a "grandfathered plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered plan can preserve certain basic coverage that was already in effect when the law was enacted. Being a grandfathered plan means that your plan may not include certain provisions of the Affordable Care Act that apply to other plans. However, grandfathered plans must comply with certain other provisions in the Affordable Care Act.

Questions regarding which provisions apply and which provisions do not apply to a grandfathered plan, and what might cause a plan to change from a grandfathered plan status can be directed to Tri-Star Systems at 1-800-727-0182. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. The website has a table summarizing which protections do and do not apply to grandfathered plans.

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 YOUR FLEXPLAN

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 Plan Administrator 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 benefits.

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

IMPORTANT INFORMATION

Name of Plan:
HSHS Flexplan

Plan Sponsor:
Hospital Sisters Health System

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

Name and Address of the Flexible Spending Accounts Claims Administrator:
Tri-Star Systems
14323 South Outer 40 Road, Suite 200 South
Chesterfield, MO 63017

PARTICIPATING EMPLOYERS:

- 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
- 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

- St. Francis Hospital
  Litchfield, Illinois
- St. John's Hospital
  Springfield, Illinois
- Holy Family Hospital
  Greenville, Illinois
- St. Joseph's Hospital
  Chippewa Falls, Wisconsin
- 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 Flexplan. 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.