FLEXPLAN

The benefits of choice

The HSHS Healthy Plan

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

CONTENTS

HEALTHY PLAN OPTIONS

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

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

- Basic Option
- High Option

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

Aetna administers the medical benefits of the HSHS Healthy Plan.

Express Scripts administers the Prescription Drug benefits of the HSHS Healthy Plan.

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

SUMMARY SCHEDULE OF BENEFITS

*The Plan pays the percentages shown. The Member pays any Copay before the applicable percentage is applied. These do not reflect any services not covered by the Plan, benefit reductions caused by not complying with precertification, or out-of-network charges that exceed Eligible Charge limits for which you are also responsible. See the **Covered Services** section for limitations that apply to some Treatments; **Utilization Review** for the pre-certification requirements that apply to some services.*

BASIC OPTION	**HSHS[1]**	**PCIN-Aetna Supplemental**	**Other Aetna**	**Out of Network**
Wellness and Preventive Care	100% no deductible			No coverage
Annual Medical Deductible	all cross apply			
Per Individual	$1,800	$1,800	$3,600	$7,000
Family Limit	$3,600	$3,600	$7,200	$14,000
Annual Medical Out-of-Pocket Limit (includes Medical Deductible)	all cross apply			
Per Individual	$3,800	$3,800	$5,400	$14,000
Family Limit	$7,600	$7,600	$10,800	$28,000
Physician Charges				
Office Visit Charge/Allergy Serums/Injections:				
PCP	100%	90%	75%*	50%*
Specialist	100%	80%	75%*	50%*
Allergy Testing and Treatment				
PCP	90%	90%	75%*	50%*
Specialist	80%*	80%*	75%*	50%*
All Other Office Procedures:				
PCP	90%	90%	75%*	50%*
Specialist	80%*	80%*	75%*	50%*
Surgery – Inpatient and Outpatient:				
PCP	90%	90%	75%*	50%*
Specialist	80%*	80%*	75%*	50%*
Spinal Manipulations (up to 10 per calendar year)	80%*	80%*	75%*	50%*
Lab and Imaging	75%	75%	75%	50%*
Walk-In Clinics	N/A	90%	75%*	50%*
Hospital Billed Services				
Inpatient	75%	N/A	55%*	50%*
Outpatient	75%	N/A	55%*	50%*
Lab and Imaging	75%	75%	55%*	50%*
Emergency Room Care				
True Emergency:				
Hospital	$100 copay then 75%	N/A	Same as HSHS[2]	Same as HSHS[2]
Physician	75%*	75%*	Same as HSHS[2]	Same as HSHS[2]
Non-Emergency Condition:				
Hospital	$300 copay then 70%	N/A	55%*	50%*
Physician	70%*	70%*	70%*	50%*
Ambulance	75%	75%	75%	75%
Skilled Nursing Facility (180 days max per calendar year)	75%	N/A	55%*	50%*
Private Duty Nursing	75%	75%	75%	50%*
Bariatric Surgery:				
Facility	75%	N/A	Not covered	Not covered
Specialist	80%*	80%*	75%*	50%*
Home Health Services (120 visit max/calendar year)	75%	75%	75%	50%*
Hospice	75%	75%	75%	50%*
Virtual Care Office Visit	100%	Not covered	Not covered	Not covered
Mental Health & Substance Abuse				
Physician (office visit, inpatient, outpatient):				
PCP	90%	90%	75%	50%*
Specialist	80%	80%	75%	50%*
Outpatient Facility	75%	75%	75%	50%*
Inpatient Facility	75%	75%	75%	50%*
Outpatient Therapy Services[3] /Cardiac Rehab / Dialysis / DME	75%	75%	75%	50%*
Skilled Nursing	75%	N/A	55%*	50%*
Other Covered Services	75%	75%	75%	50%*
Lifetime Benefit Maximum	Unlimited			

** after annual Medical Deductible is met*

[1] HSHS includes HSHS facilities, HSHS Medical Group, Prevea and Prairie Cardiovascular Consultants (PCC) providers.

[2] Same as HSHS means that the HSHS deductible, coinsurance percentage and out-of-pocket maximum apply.

[3]Therapy Services include physical, occupational and speech therapy.

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

* after annual Prescription Drug Deductible is met

If you choose to receive a brand name medication when a direct generic equivalent is available, you are responsible for paying the difference in price between the brand drug and its generic equivalent in addition to the Plan's Prescription Drug Deductible and Coinsurance.

*The Plan pays the percentages shown. The Member pays any Copay before the applicable percentage is applied. These do not reflect any services not covered by the Plan, benefit reductions caused by not complying with precertification, or out-of-network charges that exceed Eligible Charge limits for which you are also responsible. See the **Covered Services** section for limitations that apply to some Treatments; **Utilization Review** for the pre-certification requirements that apply to some services.*

HIGH OPTION	**HSHS[1]**	**PCIN-Aetna Supplemental**	**Other Aetna**	**Out of Network**
Wellness and Preventive Care	100% no deductible			No coverage
Annual Medical Deductible	all cross apply			
Per Individual	$900	$900	$1,800	$3,500
Family Limit	$1,800	$1,800	$3,600	$7,000
Annual Medical Out-of-Pocket Limit (includes Medical Deductible)	all cross apply			
Per Individual	$3,000	$3,000	$6,000	$12,000
Family Limit	$6,000	$6,000	$12,000	$24,000
Physician Charges				
Office Visit Charge/Allergy Serums/Injections:				
PCP	100%	95%	85%*	50%*
Specialist	100%	90%	85%*	50%*
Allergy Testing and Treatment:				
PCP	95%	95%	85%*	50%*
Specialist	90%*	90%*	85%*	50%*
All Other Office Procedures:				
PCP	95%	95%	85%*	50%*
Specialist	90%*	90%*	85%*	50%*
Surgery – Inpatient and Outpatient:				
PCP	95%	95%	85%*	50%*
Specialist	90%*	90%*	85%*	50%*
Spinal Manipulations (up to 10 per calendar year)	90%*	90%*	85%*	50%*
Lab and Imaging	85%	85%	85%	50%*
Walk-In Clinic	N/A	95%	85%*	50%*
Hospital Billed Services				
Inpatient	85%	N/A	65%*	50%*
Outpatient	85%	N/A	65%*	50%*
Lab and Imaging	85%	85%	65%*	50%*
Emergency Room Care				
True Emergency:				
Hospital	$100 copay then 85%	N/A	Same as HSHS[2]	Same as HSHS[2]
Physician	85%*	85%*	Same as HSHS[2]	Same as HSHS[2]
Non-Emergency Condition:				
Hospital	$300 copay then 70%	N/A	65%*	50%*
Physician	70%*	70%*	70%*	50%*
Ambulance	85%	85%	85%	85%
Skilled Nursing Facility (180 days max per calendar year)	85%	N/A	65%*	50%*
Private Duty Nursing	85%	85%	85%	50%*
Bariatric Surgery:				
Facility	85%	N/A	Not covered	Not covered
Specialist	90%	90%	85%*	50%*
Home Health Services (120 visit max/calendar year)	85%	85%	85%	50%*
Hospice	85%	85%	85%	50%*
Virtual Care Office Visit	100%	Not covered	Not covered	Not covered
Mental Health & Substance Abuse				
Physician (office visit, inpatient, outpatient):				
PCP	95%	95%	85%	50%*
Specialist	90%	90%	85%	50%*
Outpatient Facility	85%	85%	85%	50%*
Inpatient Facility	85%	85%	85%	50%*
Outpatient Therapy Services[3] /Cardiac Rehab / Dialysis / DME	85%	85%	85%	50%*
Skilled Nursing	85%	N/A	55%*	50%*
Other Covered Services	85%	85%	85%	50%*
Lifetime Benefit Maximum	Unlimited			

** after annual Medical Deductible is met*

[1] HSHS includes HSHS Medical Group and Prairie Cardiovascular Consultants (PCC providers.

[2] Advanced imaging includes PET, CAT, MRI, MRA, bone density and sleep study. [3] Same as HSHS means the HSHS Facility deductible, Coinsurance percentage, and out-of-pocket maximum apply.

[4] Therapy Services include physical, occupational and speech therapy.

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

* after annual Prescription Drug Deductible is met

If you choose to receive a brand name medication when a direct generic equivalent is available, you are responsible for paying the difference in price between the brand drug and its generic equivalent in addition to the Plan's Prescription Drug Deductible and Coinsurance.

COMMON FEATURES - BOTH OPTIONS

WELLNESS AND PREVENTIVE CARE

When provided by an HSHS provider or another Network Provider, the Plan pays 100% of Eligible Charges with no deductible for the following preventive/routine services for both options:

- Periodic recommended well-child and health education/counseling. Preventive physical exams are covered according to the following schedule:
  - 7 exams in the first 12 months of life
  - 3 exams in the second 12 months of life
  - 3 exams in the third 12 months of life
  - 1 exam per year after age 3
- Annual adult examinations, screenings, and health education/counseling.
- Routine immunizations and inoculations for infectious disease in accordance with the Centers for Disease Control and Prevention's and Advisory Committee for Immunization Practice's recommendations.
  - For adults, these include:
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV) for ages 9 to 26 years
    - Influenza
    - MMR (measles, mumps, rubella)
    - Meningococcal
    - Pneumococcal vaccine
    - Tetanus, diphtheria, pertussis (Td/Tdap)
    - Tuberculosis (TN)
    - Haemophilus influenza type b (Hib)
    - Varicella (chickenpox)
    - Shingles vaccine for members age 50 or older
  - For children, these include:
    - Diphtheria, tetanus, pertussis (DTaP or Tdap)
    - Haemophilus influenza type b (Hib)
    - Hepatitis A
    - Hepatitis B
    - Human Papillomavirus (HPV)
    - Inactivated poliovirus
    - Influenza
    - MMR (measles, mumps, rubella)
    - Meningococcal
    - Pneumococcal
    - Rotavirus for ages 0 – 32 weeks
    - Varicella (chickenpox)

    - Gonorrhea for newborns
- The Plan provides coverage for immunizations and inoculations at Network Pharmacies. The Claims Administrator also has agreements with certain retail clinics and pharmacies to provide immunizations and inoculations. Contact the Pharmacy Benefit Manager or Claims Administrator for more information.
- Gynecological examination, including pelvic and clinical breast exam, genetic counseling and evaluation for BRCA testing, cervical cancer screening including Pap smear, ovarian cancer screening, and urinalysis
- Folic acid supplementation for all women who are planning or capable of pregnancy
- Digital rectal exam (DRE) (prostate exam)
- One routine hearing screening every 12-months
- One annual depression screening
- One annual screening mammography for women (including digital breast tomosynthesis – 3D mammograms)
- Abdominal aortic aneurysm one-time screening for men, over age 65 who have smoked
- One annual colonoscopy, sigmoidoscopy, or double-contrast barium enema (both facility and Physician charges) including preparatory medications subject to reasonable medical management. Cologuard is considered preventive once every three years for individuals over age 50
- Colorectal cancer preventive medication
- Bone density screening, for individuals at risk of osteoporosis for women at any age and men age 50 or older
- The following diagnostic lab tests when ordered at the time of a covered preventive care visit: total cholesterol and HDL screening, Pap smear, blood glucose, complete blood count (CBC), high risk Human Papillomavirus (HPV) DNA testing for women age 30 and older, thyroid, prostate specific antigen (PSA) for men, HIV screening, screening for sexually transmitted infections, and fecal occult blood tests
- Routine Diagnostic Services performed in conjunction with an annual physical exam. (Diagnostic Services billed with a diagnosis are not covered under the Plan's Wellness and Preventive Care provisions. Instead, see the Plan's standard provisions for Diagnostic Services.)
- Diabetes education sessions for individuals diagnosed with diabetes
- Screening tests for children include: hearing, vision, oral health, Hematocrit or hemoglobin, obesity, lead, dyslipidemia (when higher risk of lipid disorder), tuberculin, depression, sexually transmitted infections, HIV, and cervical dysplasia. Additionally, for newborns: hypothyroidism, sickle cell disease, and phenylketonuria (PKU)
- Vision screening for children between the ages of 3 and 5 years of age to detect amblyopia or its risk factors
- Developmental testing exam for children up to 36 months of age
- Screening tests for pregnant women include: anemia, bacteriuria, Rh incompatibility, gestational diabetes, Hepatitis B, and pre-eclampsia including blood pressure measurements throughout

pregnancy

- Breastfeeding support and counseling by a trained Provider
- Breast pumps, as follows:
  - Rental of a hospital-grade electric pump for a newborn child when the newborn child is confined in a hospital
  - Purchase of:
    - An electric breast pump (non-hospital grade). A purchase will be covered once every three years; or,
    - A manual breast pump. A purchase will be covered once per pregnancy.
- Breast Pump Supplies – Coverage is limited to one item of equipment, for the same or similar purposes, and the accessories and supplies needed to operate the item. The Member is responsible for the cost of any additional pieces of the same or similar equipment purchased or rented for personal convenience or mobility. The Plan reserves the right to limit the payment of charges up to the most cost efficient and least restrictive level or service or item which can be safely and effectively provided.
- Tobacco use interventions including screening for tobacco use and two tobacco cessation attempts per year. Cessation attempt includes coverage of:
  - up to four tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization and
  - all Food and Drug Administration (FDA)-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.
- Screening and counseling services for:
  - interpersonal and domestic violence;
  - sexually transmitted diseases (counseling limited to twice per year) and
  - HIV infections.
- Screening and counseling services to aid in the prevention or reduction of the use of an alcohol agent or controlled substance, limited to 5 visits per year
- One annual lung cancer screening
- Screening and counseling services to aid in weight reduction due to obesity. The annual maximum is based on the following:
  - Age 0-22 years – unlimited visits
  - Age 22 and over – 26 visits per year, 10 visits may be used for healthy diet counseling
- Generic breast cancer risk reducing medications for women with no prior diagnosis of breast cancer. If the patient's physician determines the generic is not medically appropriate for the member and submits a request for special review, Express Scripts will review. If approved by Express Scripts, the brand name medication will be covered under the Plan's Wellness and Preventive benefits.

* Aspirin preventive medication for adults age 50 to 59 having a more than 10 percent 10-year cardiovascular risk
* Syphilis screening in non-pregnant adults and adolescents
* Latent tuberculosis infection screening
* Statin preventive medication for adults age 40 to 75 with no history of cardiovascular disease, one or more cardiovascular disease risk factors, and a calculated 10-year cardiovascular disease event risk of 10 percent or greater

The above list of covered preventive care services may change as United States Preventive Services Task Force ("USPSTF"), Centers for Disease Control and Prevention ("CDC") and Health Resources and Services Administration ("HRSA") guidelines are modified. For more information, you may access the website at www.aetna.com or contact customer service at 1-800-345-9474.

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

The HSHS Healthy Plan covers contraceptives only when Medically Necessary.

HEALTHY PARTNER

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

MEDICAL DEDUCTIBLE

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

- No deductible applies to HSHS Facility Provider or HSHS Preferred PCP Covered Expenses.
- If the Covered Expenses applied to the Medical Deductibles for covered Members of your family reach the Medical Deductible Family Limit in a Benefit Period, no additional Medical Deductible will be required for any covered family Member for the rest of that Benefit Period for the Provider category(ies) for which the Medical Deductible Family Limit has been met.
- Amounts that apply to any Medical Deductible category are credited to all other Medical Deductible categories. For example, if you receive Covered Services from an Other Aetna Network Specialist Physician that result in your meeting $100 of the Other Aetna Network Specialist Physician Medical Deductible, $100 will also be credited to the Medical Deductibles that apply to HSHS Preferred Specialist Physicians, Other Aetna Network PCP, Other Aetna Network Facility, and Out-of-Network Covered Services.
- A separate annual deductible applies to Prescription Drugs.

MEDICAL OUT-OF-POCKET MAXIMUM

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

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

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

The individual and family Medical Out-of-Pocket Maximums depend on the option you choose when you enroll, as shown in the ***Summary Schedule of Benefits,*** and whether the services you receive are provided by an HSHS Facility, HSHS Preferred PCP, HSHS Preferred Specialist, Other Aetna Network Specialist, Other Aetna Network PCP, Other Aetna Network Facility, or an Out-of-Network Provider.

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

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

Amounts that apply to any Medical Out-of-Pocket Maximum category are credited to all other Medical Out-of-Pocket Maximum categories. For example, if you receive Covered Services from an Other Aetna Network Specialist Physician that result in your meeting $100 of the Other Aetna Network Specialist Physician Medical Out-of-Pocket Maximum, $100 will also be credited to the Medical Out-of-Pocket Maximums that apply to HSHS Facility, HSHS Preferred PCP, HSHS Preferred Specialist, Other Aetna Network PCP, Other Aetna Network Facility, and Out-of-Network Covered Services.

USING HSHS FACILITY AND HSHS PREFERRED PRIMARY CARE PHYSICIAN SERVICES

To receive the highest level of benefits, you and your dependents should utilize HSHS facilities and Primary Care Physicians (PCP) that are employed by the HSHS Medical Group– no deductible and lower Coinsurance payment and out-of-pocket maximums apply. When you require care from a Specialist Physician, the Plan's benefits are the greatest when you use a Physician that is employed by HSHS Medical Group or Prairie Cardiovascular Consultants (PCC). To receive the HSHS Facility benefit level, care must be billed under an HSHS provider ID number on a UB form.

Using Providers that are part of PCIN or Aetna Supplemental provides the next best benefit.

Go to benefits.hshs.org and select the "Find a Provider – HSHS Healthy Plan - Aetna" link to locate a Network Provider. A list of HSHS Facilities is provided in Appendix A.

NETWORK PROVIDERS

Although you can go to the Hospital of your choice, the Plan's benefits for facility charges are greatest when you use HSHS Facility providers. For physician services, the Plan's benefits are greatest when you receive care from HSHS Medical Group. When you require care from a Specialist, the Plan's benefits are greatest when you use a HSHS Medical Group or Prairie Cardiovascular Consultants Specialist. And the Plan's benefits are greater when services are received from Network Providers than they are when services are received from an Out-of-Network Provider. Network Providers include:

- HSHS Facilities
- HSHS Preferred PCPs
- HSHS Preferred Specialists
- Other Aetna Network Providers

A list of HSHS Facilities is provided in Appendix A.

- You can find a Network Provider on benefits.hshs.org. Select the "Find a Provider – HSHS Healthy Plan - Aetna" link or call the toll free telephone number on your identification card. As there may be changes in the network from time to time, you are urged to check with the Provider before receiving Treatment to verify the Provider's network status. *Please see important information under* ***Aetna Network Facility Providers Excluded***

from Coverage *on the next page regarding facilities that participate in the Aetna network that are considered Out-of-Network by this Plan.*

- Although dentists are not included in the Aetna provider network, dentists are treated as Network Providers for purposes of determining the Plan's benefit payment level. However, they may bill you for the difference between the Claim Administrator's Eligible Charge and the amount they charge you.

Using Non HSHS Network Facility Services – Inpatient and outpatient facility charges, other than emergency room charges, incurred at non-HSHS Facilities are subject to an annual Medical Deductible. Once the annual Medical Deductible is met, the percentage of Covered Expenses that is paid by the Plan is 20% less than the percentage that applies to HSHS Facility charges for the majority of Covered Services. Additionally, the Medical Out-of-Pocket Maximums that apply to non HSHS Network Facilities are higher than those that apply to services received from HSHS Facilities.

Aetna Network Facility Providers Excluded from Coverage - Although they participate in the general Aetna network, the HSHS Healthy Plan will not cover facility charges for services you receive from any of the following:

Abraham Lincoln Memorial Hospital (Lincoln, IL)

Anderson Hospital (Maryville, IL)

Apex Physical Therapy – *All the following locations are excluded except for HSHS Holy Family Greenville locations (Beardstown, Belleville, Bethalto, Breese, Chester, Collinsville, Columbia, Glen Carbon, Effingham, Forsyth, Freeburg, Gillespie, Godfrey, Granite City, Highland, Lebanon, Lincoln, Litchfield, Maryville, Mascoutah, Mt Zion, O'Fallon, Paris, Smithton, Troy, Waterloo, Wood River, IL)*

Aspirus (Wassau, Weston, WI)

ATI Physical Therapy Locations (Springfield, IL)

BJC Facilities

- *Alton Memorial (Alton, IL)*
- *Alton Memorial Hospital Sports Performance Center (Alton, IL)*
- *BJC Home Care Services (Alton, IL and Park Hills, St. Louis, Sullivan, MO)*
- *BJC Home Medical Equipment (Alton, IL and Park Hills, St. Louis, Sullivan, MO)*
- *BJC Hospice (Alton, IL and Park Hills, St. Louis, Sullivan, MO)*
- *BJC Rehabilitation and Spine Center (St. Louis, MO)*
- *Barnes-Jewish Extended Care (St. Louis, MO and Clayton, MO)*
- *Barnes-Jewish Hospital (St. Louis, MO)*
- *Barnes-Jewish Hospital – Physical Medicine and Rehabilitation (St. Louis, MO)*
- *Barnes-Jewish St. Peters Hospital, (St. Peters, MO)*

BJC Facilities (Continued)

- *Barnes-Jewish St. Peters Hospital Therapy Services (St. Peters, MO)*
- *Barnes-Jewish West County Hospital (St. Louis, MO)*
- *Barnes-Jewish West County Hospital STAR: Sports Therapy and Rehabilitation (Creve Coeur, MO and Chesterfield, MO)*
- *Boone Hospital Center (Columbia, MO)*
- *Boone Hospital Home Care (Columbia, MO)*
- *Boone Hospital Therapy (Columbia, MO)*
- *Christian Hospital (St. Louis, MO)*
- *Christian Hospital Northeast (St. Louis, MO)*
- *Christian Hospital Outpatient Therapies (Florissant, MO)*
- *Eunice Smith Home (Alton, IL)*
- *Heart Care Institute (St. Louis, MO)*
- *Heart Care Institute Ambulatory Services (St. Louis, MO)*
- *Heart Care Institute Intensive Cardiac Rehab (St. Louis, MO)*
- *Human Motion Institute Rehabilitation Services (Alton, IL)*
- *Memorial Hospital (Belleville, IL)*
- *Memorial Hospital East (Shiloh, IL)*
- *Milliken Hand Center (Chesterfield, St. Louis, MO)*
- *Missouri Baptist Medical Center (St. Louis, MO)*
- *Missouri Baptist Medical Center Outpatient Rehabilitation (St. Louis, MO)*
- *Missouri Baptist Sullivan Hospital (Sullivan, MO)*

BJC Facilities (Continued)

- *Missouri Baptist Sullivan Hospital Sports, Fitness and Rehabilitation Center (Sullivan, Cuba, MO) also known as Sports and Rehab Center – Cuba and Sullivan Sports & Rehab Center*
- *Northwest HealthCare (Florissant, MO)*

Fayette County Hospital (Vandalia, IL)

Lakeview Medical Center (Rice Lake, WI)

Marshfield Clinic Center (Eau Claire, WI)

Marshfield Clinic Center (Marshfield, WI)

Marshfield Clinic Center (Minocqua, WI)

- *Parkland Health Center (Farmington, MO)*
- *Parkland Health Center Therapy Services (Bonne Terre, Farmington, MO)*
- *Progress West Hospital (O'Fallon, MO)*
- *St. Louis Children's Hospital (St. Louis, MO)*
- *St. Louis Children's Hospital – Pediatric Rehabilitation (Chesterfield, St. Louis, MO)*
- *The Rehabilitation Institute of St. Louis (St. Louis, MO)*
- *Transitional Care Program (Sullivan, MO)*
- *Transitional Care Unit (Alton, IL)*
- *Twin Rivers MRI (Alton, IL)*
- *Village North Health Center, also known as Village North Retirement Community, Rehabilitation and Nursing Center (St. Louis, MO)*

Carle Hospital (Champaign, IL)

Decatur Memorial Hospital (Decatur, IL)

Effingham Surgical Center (Effingham, IL)

Elite Imaging (Fairview Heights, IL)

Express Care – Anderson (Highland, Collinsville, Glen Carbon, Bethalto, IL)

Marshfield Clinic Center (Wausau WI)

Mayo-Bloomer Hospital (Bloomer, WI)

Mayo-Franciscan Skemp Hospital (Lacrosse, WI)Mayo-Osseo Hospital (Osseo, WI)

Mayo-Red Cedar Hospital (Menomonie, WI)

Mayo Luther Midelfort Hospital (Eau Claire, WI)

Mayo Northland Hospital (Barron, WI)

MedExpress Locations (All locations, IL/MO)

Memorial Medical Center (Springfield, IL)

Ministry St. Clare Hospital (Weston, WI)

Ministry St. Joseph's Hospital (Marshfield, WI)

Orthopedic Center of Illinois (OCI) (Springfield, IL)

Passavant Hospital (Jacksonville, IL)

Phoenix Physical Therapy (Swansea, Highland, East Alton, Greenville, Breese, Vandalia, Shelbyville, IL)

Sara Busch Lincoln (Mattoon, IL)

Springfield Clinic – Ambulatory Surgery Center (Springfield, IL)

Taylorville Memorial Hospital (Taylorville, IL)

OUT-OF-NETWORK PROVIDERS

LIMITED BENEFITS WILL BE PAID WHEN OUT-OF-NETWORK PROVIDERS ARE USED
When you elect to utilize the services of a Provider other than an HSHS Provider and that Provider does not participate in the Aetna Network a higher Medical Deductible, higher Coinsurance payments and higher Medical Out-of-Pocket Maximums apply to most services.

Benefit payments to such Out-of-Network Provider are not based upon the amount billed. The basis of the Plan's benefit payment will be determined according to Aetna's Eligible Charge. ***You can expect to pay more than the Coinsurance amount specified in the Schedule of Benefits after the Plan has paid its required portion***. Out-of-Network Providers may bill Members for any amount up to the billed charge after the Plan has paid its portion of the bill. HSHS Facility Providers, HSHS Preferred PCPs, HSHS Preferred Specialists, Other Aetna Network Specialists, Other Aetna Network PCPs, and Other Aetna Network Facilities have agreed to accept discounted payments for services with no additional billing to the Member other than Coinsurance and the Medical Deductible amounts.

SPECIAL CIRCUMSTANCES

With the Exception of Bariatric Surgery, When No HSHS Facility Offers The Medical Service You Need Within 65 Miles Of Your Home – the HSHS Medical Deductibles and Medical Out-of-Pocket Maximums for your option apply when you receive that service from a Network Provider **and** the care is received more than 65 miles from an HSHS facility that provides the required service. This special provision only applies to facility charges billed on a UB form by a Network Provider. The Coinsurance that applies is as specified in the ***Summary Schedule of Benefits*** for the option in which you are enrolled. You must file a request with the Claim Administrator for this special provision to apply. The request for the claim adjustment must be made within one year of the date of service.

For True Medical Emergencies, Medical Emergency and Emergency Accident facility charges are covered at the HSHS benefit level, whether you go to an HSHS or another facility, regardless

of whether that facility participates in the Aetna network. Likewise, Medical Emergency and Emergency Accident Specialist Physician charges are covered at the HSHS Preferred Specialist benefit level, regardless of whether the Specialist is an HSHS Preferred Specialist or participates in the Aetna network. Finally, Medical Emergency and Emergency Accident PCP charges are covered at the HSHS Preferred Specialist benefit level, if the PCP is an Aetna Network PCP or an Out-of-Network PCP. True emergencies may include seizures, loss of consciousness, severe and/or persistent chest pain, severe bleeding and shortness of breath.

PRESCRIPTION DRUGS

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

- If the Covered Expenses applied to the Prescription Drug Deductibles for covered Members of your family reach the Prescription Drug Deductible Family Limit in a Benefit Period, no additional Prescription Drug Deductible will be required for any covered family Member for the rest of that Benefit Period. (The Ancillary Fee does not apply to the Prescription Drug Deductible.)
- If the Prescription Drug out-of-pocket expenses for all your covered family Members combined reach the Prescription Drug Out-of-Pocket Maximum Family Limit in a Benefit Period, the Plan will pay 100% of any additional Prescription Drug Covered Expenses for any covered family Member for the rest of that Benefit Period. (The Ancillary Fee does not apply to the Prescription Drug Out-of-Pocket Maximum. Ancillary Fees are not limited by the Prescription Drug Out-of-Pocket Maximum.)

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

Network Pharmacy Use Required for Benefits - Prescriptions must be obtained from an Express Scripts network retail or home delivery pharmacy to be covered.

30 Day Supply at Retail/90 Day Through Mail - Up to a 30-day supply per prescription of a covered Prescription Drug is covered at a retail Network Pharmacy. Up to a 90-day supply per prescription of a covered Prescription Drug is covered through Express Scripts' home delivery pharmacy.

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

Formulary Benefit Difference - For brand-name drugs that are not on the Express Scripts Formulary list, the additional $15 retail pharmacy co-pay and $45 mail order co-pay per prescription for non-Formulary medications do not count toward your annual Prescription Drug Deductible.

To find out if your medication is on the Formulary, go to www.express-scripts.com/hshs or call 1-800-698-3757.

Mail Service Required for Maintenance Drug Benefits - In order to receive Prescription Drug benefits through the HSHS Healthy Plan, you will be required to use Express Scripts' mail service after having a maintenance medication filled two times at a retail pharmacy.

To find a list of common maintenance medications, go to www.express-scripts.com/hshs or call 1-800-698-3757.

Specialty Pharmacy Required for Specialty Drug Benefits - If you take any self-administered oral or injectable specialty medications, you must purchase these medications through Express Scripts' specialty pharmacy or an HSHS pharmacy, for the medication to be covered by the HSHS Healthy Plan. Specialty medications include those used to treat multiple sclerosis, hepatitis C, rheumatoid arthritis, hemophilia and self-administered oral cancer medications. You may fill your initial prescription for a covered medication at a retail pharmacy and have its cost covered by the Plan. After that, you must use either Express Scripts' specialty pharmacy or an HSHS pharmacy to have subsequent refills covered.

Prior Authorization, Quantity Limitations, and Step Therapy - Some medications require prior authorization by Express Scripts in order to be covered. Some medications are subject to quantity limitations. Step therapy applies to some medications - before these medications are covered by the Plan, you may need to first try a proven, cost-effective medication. If your doctor determines that a first-line drug is not appropriate or effective for you, the Plan will cover a second-line drug when certain conditions are met. The medications to which these provisions apply are subject to change. ***To find a list of medications to which these provisions apply, go to www.express-scripts.com/hshs or call 1-800-698-3757.***

ELIGIBLE CHARGE LIMITS

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

Out-of-network providers have not agreed to accept the negotiated charge. Aetna will reimburse you for a Covered Expense, incurred from an out-of-network provider, up to the Eligible Charge and the maximum benefits under this Plan, less any cost-sharing required by you such as deductibles and payment percentage. The Eligible Charge is the maximum amount Aetna will pay for a Covered Expense from an out-of-network provider. Your payment percentage is based on the Eligible Charge. If your out-of-network provider charges more than the Eligible Charge, you will be responsible for any expenses incurred above the Eligible Charge. Except for emergency services, Aetna will only pay up to the Eligible Charge.

RECOGNIZED CHARGE

The amount of an Out-of-Network Provider's charge that is eligible for coverage. You are responsible for all amounts above what is eligible for coverage.

The recognized charge depends on the geographic area where you receive the service or supply. The table below shows the method for calculating the recognized charge for specific services or supplies:

Service or supply	Recognized charge
Professional services and other services or supplies not mentioned below	100% of the Medicare allowable rate
Services of hospitals and other facilities	100% of the Medicare allowable rate
Important note: If the provider bills less than the amount calculated using the method above, the recognized charge is what the provider bills.	

Recognized charge does not apply to involuntary services.

If your ID card displays the National Advantage Program (NAP) logo your cost may be lower when you get care from a NAP provider. NAP providers are Out-of-Network Providers and third party vendors that have contracts with us but are not Network Providers. Except for involuntary services, when you get care from a NAP Provider your Out-of-Network cost sharing applies.

Special terms used

- Geographic area is normally based on the first three digits of the U.S. Postal Service zip codes. If we determine we need more data for a particular service or supply, we may base rates on a wider geographic area such as an entire state.
- Involuntary services are services or supplies that are one of the following:
    - Performed at a Network Facility by an Out-of-Network Provider, unless that Out-of-Network Provider is an assistant surgery for your surgery
    - Not available from a Network Provider
    - Emergency services

  We will calculate your cost share for involuntary services in the same way as we would if you received the services from a Network Provider.
- Medicare allowed rates are the rates CMS establishes for services and supplies provided to Medicare enrollees We update our systems with these revised rates within 180 days of receiving them from CMS. If Medicare does not have a rate, we use one or more of the items below to determine the rate:
    - The method CMS uses to set Medicare rates
    - What other Providers charge or accept as payment
    - How much work it takes to perform a service
    - Other things as needed to decide what rate is reasonable for a particular service or supply

  We may make the following exceptions:
    - For inpatient services, our rate may exclude amounts CMS allows for Operating Indirect Medical Education (IME) and Direct Graduate Medical Education (DGME)
    - Our rate may also exclude other payments that CMS may make directly to hospitals or other Providers. It also may exclude any backdated adjustments made

by CMS.

- For anesthesia, our rate is 105% of the rates CMS establishes for those services or supplies.
- For laboratory, our rate is 75% of the rates CMS establishes for those services or supplies
- For durable medical equipment, our rate is 75% of the rates CMS establishes for those services or supplies
- For medications payable/covered as medical benefits rather than prescription drug benefits, our rate is 100% of the rates CMS establishes for those medications.

We reserve the right to apply our reimbursement policies to all Out-of-Network services including involuntary services. Our reimbursement policies may affect the recognized charge. These policies consider:

- The duration and complexity of a service
- When multiple procedures are billed at the same time, whether additional overhead is required
- Whether an assistant surgeon is necessary for the service
- If follow-up care is included
- Whether other characteristics modify or make a particular service unique
- When a charge includes more than one claim line, whether any services described by a claim line are part of our related to the primary service provided
- The educational level, licensure or length of training of the Provider

Our reimbursement policies are based on our review of:

- The CMS National Correct Coding Initiative (NCCI) and other external materials that say what billing and coding practices are and are not appropriate
- Generally accepted standards of medical and dental practice
- The views of Physicians and dentists practicing in the relevant clinical areas

We use commercial software to administer some of these policies. The policies may be different for professional services and facility services.

NECESSARY MEDICAL CARE

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

Any expense for which a Covered Person has no legal obligation to pay or for which no charge would be made if the Covered Person was not covered under the Plan are not covered by the Plan.

Expenses for services or supplies for which a healthcare Provider specifically limits its charges to only those paid by this Plan are not covered by the Plan.

Please review the ***Utilization Review*** section for the pre-certification requirements that apply to some services in order to receive full benefits under the Plan.

DEFINITIONS

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

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

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

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

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

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

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

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

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

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

Autism Spectrum Disorders: A broad range of developmental disorders, which includes autism, Asperger's syndrome, pervasive development disorder, Rhett's disorder, and childhood disintegrative disorder (CDD).

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Claim Administrator: Aetna.

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

Claim Form: the form posted on the Claims Administrator's web site to be used to notify the

Claim Administrator that a service has been rendered or furnished to you

Clinical Efficacy: the Treatment satisfies both of the following:

a) it can reasonably be expected to improve survival, health or function to alleviate symptoms of or stabilize that condition; and

b) its use outweighs any potential harm.

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

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

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

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

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

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

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

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

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

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

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

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

Durable Medical Equipment: equipment which is primarily and customarily used for treatment of an illness or Injury and made to withstand repeated use. Durable Medical Equipment includes: wheelchairs, hospital beds, internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices.

Includes oral devices/appliances used to reduce upper airway collapsibility or obstructive sleep apnea, adjustable or non-adjustable, custom fabricated if medically necessary. Includes fitting and adjustment.

Eligible Charge: (a) in the case of a Network Provider, the amount the Network Provider has agreed to for a covered service (b) in the case of a Professional Provider that is an Out-of-Network Provider at the time Covered Services are rendered, will be the lesser of

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

(ii) 100% of the Medicare allowable rate for Professional Providers or 50% of the Medicare allowable rate for non-Professional Providers.

(c) in the case of a facility Provider that is an Out-of-Network Provider at the time Covered Services are rendered, will be the lesser of:

(i) the Provider's Claim Charge, or

(ii) the FCR Rate

If the Provider is a NAP Provider, the Eligible Charge will be the lesser of:

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

(ii) the amount the Claim Administrator has negotiated with the Provider.

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

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

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

Experimental or Investigational: A drug, a device, a procedure, or treatment will be determined to be experimental or investigational if:

1. there are insufficient outcomes data available from controlled clinical trials published in the peer-reviewed literature to substantiate its safety and effectiveness for the illness or injury involved; or
2. approval required by the U. S. Food and Drug Administration (FDA) has not been granted for marketing; or
3. a recognized national medical or dental society or regulatory agency has determined, in writing, that it is experimental or investigational, or for research purposes; or
4. it is a type of drug, device, procedure or treatment that is the subject of a Phase I or Phase II clinical trial or the experimental or research arm of a Phase III clinical trial, using the definition of "phases" indicated in regulations and other official actions and publications of the FDA and Department of Health and Human Services; or
5. the written protocol or protocols used by the treating facility, or the protocol or protocols of any other facility studying substantially the same drug, device, procedure, treatment, or the written informed consent used by the treating facility or by another facility states that it is experimental or investigational or for research purposes.

Extended Care Facility (or Skilled Nursing Facility): an institution or a distinct part of an

institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services, and which:

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

Facility Charge Review (FCR): The amount the Claim Administrator determines is enough to cover the Provider's estimated costs for the service and leave the Provider with a reasonable profit. For hospitals and other facilities which report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on the information facilities report to CMS. For facilities which do not report costs (or cost-to-charge ratios) to CMS, the FCR rate is based on statewide averages of the facilities that do report to CMS. The Claim Administrator may adjust the formula as needed to maintain the reasonableness of the Eligible Charge. For example, the Claim Administrator may make an adjustment if they determine that in a particular state the charges of ambulatory surgery centers (or another class of facility) are much higher than charges of facilities that report costs (or cost-to-charge ratios) to CMS.

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

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

Generally Accepted by the Medical Community in the United States: the Clinical Efficacy of the Treatment has been documented in credible published medical literature and generally recognized by the relevant medical community. Otherwise, the Treatment is consistent with Physician specialty society recommendations.

Gestational Surrogacy Contract: A legal agreement whereby a woman agrees to carry a pregnancy for another person or person, who will become the newborn child′s parent(s) after birth.

Gestational Surrogate: A person used as a surrogate mother to conceive or carry an embryo.

Habilitative Services: Occupational Therapy, Physical Therapy, Speech Therapy, and other services prescribed by a Physician pursuant to a Treatment plan to enhance the ability of a Covered Person to function.

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

- Physicians, nurse practitioners and physician assistants who practice within the scope of their professional license.
- For treatment of mental health disorders or chemical dependency, this term will include a clinical psychologist with a graduate degree, a social worker with a graduate degree (MSW), a licensed social worker and a certified therapist who is working under the direct supervision of a physician or psychologist.

- For treatment of eye diseases and Injuries, this term will include an optometrist who is working under the direct supervision of a physician.
- Certified Registered Nurse
- Home Health Care Agency
- Hospice
- Hospital
- Licensed occupational therapists, licensed professional physical therapists, physiotherapists, and speech language pathologists.
- Urgent Care Center - A health care facility that is organizationally separate from a Hospital and whose primary purpose is the offering and provision of immediate, short-term medical care, without appointment, to treat an unexpected episode of illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care, but is not considered a Medical Emergency. The facility must be licensed based on applicable state and federal laws to treat an Urgent Condition.

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

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

Hour of Service: any hour for which you are paid, or entitled to payment, for (1) the performance of duties for HSHS or (2) for a period of time during which no duties are performed due to vacation, holiday, illness, incapacity (including disability), layoff, jury duty, military duty, or leave of absence. An Hour of Service does not include:

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

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

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

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

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

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

HSHS Preferred Primary Care Physician (or HSHS Preferred PCP): a Primary Care Physician designated as a Preferred PCP by HSHS and includes Primary Care Physicians that have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons You can find a link to locate HSHS Preferred PCPs at benefits.hshs.org.

HSHS Preferred Specialist Physician (or HSHS Preferred Specialist): a Specialist Physician designated as a Preferred Specialist by HSHS and includes Specialist Physicians that have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons. You can find a link to locate HSHS Preferred Specialists at benefits.hshs.org.

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

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

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

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

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

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.

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

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

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

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

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

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

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

Medical Necessity or Medically Necessary: a treatment will be considered Medically Necessary with respect to a specific condition if its Clinical Efficacy has been generally accepted by the medical community in the United States and if it satisfies all of the following:

1. It is legal;
2. It is ordered by a Physician or other personnel licensed to treat that condition;
3. It is administered with the appropriate frequency, quantity, duration and level of service; and
4. It is not redundant when combined with other treatment being rendered.
5. It is not mostly for the convenience of the patient, Physician, or other Provider.
6. It does not cost more than an alternative service or sequence of services at least as likely to produce the same therapeutic or diagnostic results.

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

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

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

Mental Illness: those illnesses classified as disorders in the current *Diagnostic and Statistical*

Manual of Mental Disorders published by the American Psychiatric Association.

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

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

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

Morbid Obesity: a condition where a Covered Person has:

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

National Advantage Program (NAP) Provider: A Provider with whom the Claim Administrator has a contract through a third party that is not an affiliate of the Claim Administrator. A NAP provider is considered an Out-of-Network Provider.

Network Provider: an HSHS Facility and any other Hospitals, Ambulatory Surgical Facilities or other facilities that have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to a Covered Person and that are not specifically excluded in the ***Common Features – All Options*** section of this SPD. Additionally, HSHS Preferred Primary Care Physicians, HSHS Preferred Specialist Physicians, and Professional Providers that have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons (Network Professional Providers).

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

Network Specialist Physician (or Network Specialist): a Professional Provider that has a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons who is not a Primary Care Physician.

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

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

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

Occupational Therapy: constructive therapeutic activity designed to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, Injury or surgical procedure or to relearn skills to significantly improve independence in the Activities of Daily Living. Occupational Therapy does not include educational training or services designed to develop physical function.

Other Aetna Network Facility: a Hospital, Ambulatory Surgical Facility or other type of facility that has a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to a Covered Person, that is not specifically designated as excluded in the ***Common Features – All Options*** section of this SPD, and that is not an HSHS Facility.

Other Aetna Network Primary Care Physician (or Other Aetna Network PCP): a Professional Provider that has a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons who is a Primary Care Physician, but who is not an HSHS Preferred PCP.

Other Aetna Network Specialist Physician (or Other Aetna Network Specialist): a Professional Provider that has a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons who is a Specialist Physician, but who is not an HSHS Preferred Specialist.

Out-of-Network Provider: any Hospital, Ambulatory Surgical Facility or other facility, other than an HSHS Facility, that does not have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons. Additionally, Professional Providers, other than HSHS Preferred PCPs and HSHS Preferred Specialists, that do not have a written agreement with the Claim Administrator to provide services for the Preferred Provider Option that applies to Covered Persons (Out-of-Network Professional Providers).

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

Partial Hospitalization Treatment Program: a planned program of a Hospital or Substance Abuse Treatment Facility for the Treatment of Mental Illness or Substance Abuse in which patients spend days or nights.

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

Pharmacy Benefit Manager: Express Scripts.

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

Physical Therapy: the treatment of a non-chronic disease, Injury or condition by physical means by a Physician or a registered professional physical therapist under the supervision of a

Physician and which is designed to significantly improve, develop or restore physical functions lost or impaired as a result of an acute illness, Injury or surgical procedure. Physical Therapy does not include educational training or services designed to develop physical function.

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

Plan: the HSHS Healthy Plan

Plan Administrator: Hospital Sisters Health System.

Plan Sponsor: Hospital Sisters Health System

Plan Year: the calendar year.

Preferred Provider Option: a program of health care benefits designed to provide economic incentives for using designated Providers of health care services.

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

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

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

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

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

Primary Care Physician (PCP): a Professional Provider who is a general practice Physician, a family practice Physician, an internal medicine Physician, a Physician Assistant, a Certified Nurse Practitioner or a pediatric Physician.

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

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

Provider: has the same meaning as Health Care Provider.

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

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

(b) clearly specifies:

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

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

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

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

Residential Treatment Center (Mental Disorders): an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP) or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family/support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care must be consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Mental Health Residential Treatment Programs:

- A behavioral health provider must be actively on duty 24 hours per day for 7 days a week;
- The patient is treated by a psychiatrist at least once per week; and
- The medical director must be a psychiatrist.

Residential Treatment Facility (Substance Abuse): an institution that meets all of the following requirements:

- Is accredited by one of the following agencies, commissions or committees for the services being provided: The Joint Commission (TJC), Committee on Accreditation of Rehabilitation Facilities (CARF), American Osteopathic Association's Healthcare Facilities Accreditation Program (HFAP), or the Council on Accreditation (COA); or is credentialed by Aetna;
- Meets all applicable licensing standards established by the jurisdiction in which it is located;
- Performs a comprehensive patient assessment preferably before admission, but at least upon admission;
- Creates individualized active treatment plans directed toward the alleviation of the impairment that caused the admission;
- Has the ability to involve family and/or support systems in the therapeutic process;
- Has the level of skilled intervention and provision of care that is consistent with the patient's illness and risk;
- Provides access to psychiatric care by a psychiatrist as necessary for the provision of such care;
- Provides treatment services that are managed by a behavioral health provider who functions under the direction/supervision of a medical director; and
- Is not a wilderness treatment program (whether or not the program is part of a licensed residential treatment facility, or otherwise licensed institution), educational services, schooling or any such related or similar program, including therapeutic programs within a school setting.

In addition to the above requirements, for Chemical Dependence Residential Treatment Programs:

- Is a behavioral health provider or an appropriately state certified professional (for example, CADC, CAC);
- Is actively on duty during the day and evening therapeutic programming; and
- The medical director must be a physician who is an addiction specialist.

In addition to the above requirements, for Chemical Dependence Detoxification Programs within a residential setting:

- An R.N. is onsite 24 hours per day for 7 days a week; and
- The care must be provided under the direct supervision of a physician.

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

Rule of Parity: Under the Rule of Parity, you will be considered to have had a Break in Service if you have a period of at least four weeks during which you do not have an Hour of Service and the

period without an Hour of Service is greater than your immediately preceding period of employment with the Employer.

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

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

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

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

Specialist Physician (or Specialist): a Professional Provider who is not a general practice Physician, a family practice Physician, an internal medicine Physician, a Physician Assistant, a Certified Nurse Practitioner or a pediatric Physician.

Speech Therapy: the Treatment for the correction of a speech impairment resulting from non-chronic conditions or acute illness or Injury provided the Treatment is expected to restore the speech function or correct a speech impairment or for delays in speech function development as a result of gross anatomical defect present at birth.

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

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

Standard Stability Period: The Plan Year.

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

Substance Abuse: the physical or psychological dependency, or both, on a controlled substance or alcohol agent as defined on Axis I in the Diagnostic and Statistical Manual of Mental Disorders (DSM) published by the American Psychiatric Association which is current as of the date services are rendered. This term does not include conditions not attributable to a mental disorder that are a focus of attention or treatment (the V codes on Axis I of DSM), an addiction to nicotine products, food, or caffeine intoxication.

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

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

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

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

Urgent Condition: An illness or Injury that requires prompt medical attention but is not a Medical Emergency.

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

ELIGIBILITY

ELIGIBLE COLLEAGUES

To be eligible for coverage 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 or qualify under the Plan's ***Lookback Eligibility Method.*** You are eligible under the ***Lookback Eligibility Method*** during a Stability Period associated with a Plan Measurement Period during which you averaged 30 or more Hours of Service per week.
   a. For the January 1, 2018 – December 31, 2018 Plan Year, if you became a Colleague on or before October 16, 2016, January 1, 2018 thru December 31, 2018 is your Stability Period, which is the Plan's Standard Stability Period. You are eligible to participate in the Plan during this Stability Period if you averaged 30 or more Hours of Service per week during the Plan's Standard Measurement Period of October 16, 2016 through October 15, 2017, provided you continue to be a Colleague and to make any required contributions toward your coverage.
   b. If you become a Colleague after October 16, 2016, your Initial Measurement Period begins on the first day of the month on or following the date you become a Colleague

and ends on the last day of the month 12 months later. Your Initial Stability Period begins on the first day of the month one month following the end of your Initial Measurement Period. (For example, if you were hired on January 2, 2017, your Initial Measurement Period is February 1, 2017 through January 31, 2018. Your Initial Stability Period is March 1, 2018 through February 28, 2019. You are eligible to participate in the Plan during this Stability Period if you averaged 30 or more Hours of Service per week during your Initial Measurement Period of February 1, 2017 through January 31, 2018, provided you continue to be a Colleague and to make any required contributions toward your coverage.)

c. For Plan Years beginning January 1, 2018 or later, the Plan's Standard Measurement Period is October 16 of the calendar year two years prior to the first day of the Plan Year through October 15 of the calendar year preceding the first day of the Plan Year. The Plan's Standard Stability Period is the Plan Year.

For the January 1, 2018 – December 31, 2018 Plan Year, the Plan's Standard Measurement Period is October 16, 2016 through October 15, 2017. The Plan's Standard Stability Period is January 1, 2018 – December 31, 2018.

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

3. You are not a leased employee. Leased employees are not eligible to participate in the Plan.
4. You cannot reside in Wisconsin. For the health benefits that apply to HSHS Healthy Plan Members who reside in Wisconsin, please see the Wisconsin Healthy Plan SPD.
5. You are not a carpenter or painter employed by St. John's Hospital in Springfield, Illinois who is a member of a collective bargaining unit. Carpenters and painters employed by St. John's Hospital in Springfield, Illinois who are members of a collective bargaining unit are not eligible to participate in this Plan.
6. You are not a medical resident on St. John's Hospital in Springfield, Illinois payroll. Medical residents on St. John's Hospital in Springfield, Illinois payroll are not eligible to participate in this Plan

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.

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

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

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

DEPENDENT ELIGIBILITY

Your dependents eligible for coverage under the Plan include:

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

LOOKBACK ELIGIBILITY METHOD

The Plan's Lookback Eligibility Method works like this.

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

Here is an example:

Ann has 1642 Hours of Service from October 16, 2016 through October 15, 2017, which is more than 30 Hours of Service a week, on average, during the Plan's Standard Measurement Period for the January 1, 2018 – December 31, 2018 Plan Year. She is therefore considered eligible for benefits during the Plan's Standard Stability Period from January 1, 2018 through December 31, 2018 as long as she continues to be a Colleague and to make any required contributions toward Plan coverage.

Ongoing Colleagues

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

- For the January 1, 2018 – December 31, 2018 Plan Year, the Plan's Standard Measurement Period is October 16, 2016 – October 15, 2017. The Plan's Standard Stability Period is January 1, 2018 – December 31, 2018.
- For the January 1, 2019 – December 31, 2019 Plan Year, the Plan's Standard Measurement Period is October 16, 2017 through October 15, 2018. The Plan's Standard Stability Period is January 1, 2019 – December 31, 2019. Subsequent Plan Years follow this same schedule, the Standard Stability Period is the Plan Year; the Standard Measurement Period is October 16 of the

calendar year two years prior to the first day of the Plan Year through October 15 of the calendar year preceding the first day of the Plan Year.

New Colleagues

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

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

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

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

Changes in Job Classification during Your Initial Measurement Period

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

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

Changes in Job Classification following Your Initial Measurement Period

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

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

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

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

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

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

FAILURE TO ENROLL WHEN FIRST ELIGIBLE

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

ANNUAL ENROLLMENT

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

WHEN COVERAGE BEGINS

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

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

WHEN COVERAGE BEGINS FOR YOUR DEPENDENTS

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

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

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

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

CHANGING YOUR HEALTH PLAN COVERAGE

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

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

- **Legal marital status change**, including marriage, death of a spouse/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/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 medical eligibility.
- **Your child satisfies or ceases to satisfy the Dependent Eligibility requirements** specified in the Dependent Eligibility section.
- **Your spouse, your eligible child, or your eligible child's spouse moves to an area where he/she is outside the service area for his/her employer's medical plan -** you may add your spouse and/or children eligible to participate in this Plan who were previously covered under that plan to this Plan.
- **Change in other medical coverage as a result of your spouse's/LDA's employer's annual enrollment -** If you and/or your Dependents become covered by or lose coverage through another medical plan as a result of your spouse's/LDA's employer's annual enrollment which occurs at a different time than that of this Plan, you may change your HSHS Healthy Plan coverage accordingly. However, your election to change your coverage must be made within

30 days of when your spouse's medical coverage change becomes effective.

- **Change in other medical coverage as a result of your child's employer's annual enrollment or the annual enrollment of the employer of your child's spouse** - If your child who meets the Plan's ***Dependent Eligibility*** requirements becomes covered by or loses coverage through another medical plan as a result of his/her employer's annual enrollment or his/her spouse's employer's annual enrollment which occurs at a different time than that of this Plan, you may change your HSHS Healthy Plan coverage accordingly. However, your election to change your coverage must be made within 30 days of when your eligible child's medical coverage change becomes effective.
- **Significant change in the cost of medical coverage** under this Plan or a plan available through your spouse's/LDA's employer, eligible child's employer, or employer of your eligible child's spouse.
- **Significant change in the medical coverage available** through your spouse's/LDA's employer, eligible child's employer, or employer of your eligible child's spouse.
- If you are enrolled in Plan coverage and your hours are reduced to less than 30 per week from regularly scheduled 30 or more per week or you averaged 30 or more Hours of Service per week during the Measurement Period applicable to your current Stability Period, you can discontinue coverage under this Plan for yourself and any enrolled Dependents provided you intend to enroll yourself and any Dependents currently enrolled in this Plan in another plan that provides Minimum Essential Coverage.
- If you are enrolled in Plan coverage and yours hour classification changes resulting in a significant increase in your cost of coverage, you may change your election to a less expensive Plan option for yourself and any enrolled Dependents.

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

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

or

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

or

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

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

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

SPECIAL ENROLLMENT PERIODS

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

a. you are eligible for coverage at that time;

b. if the other health insurance coverage was COBRA continuation coverage, such coverage has been "exhausted";

c. if the other health insurance coverage was not COBRA continuation coverage, employer contributions toward the cost of such coverage have terminated or the individuals covered under the other health insurance coverage cease to be eligible for that coverage; and

d. you request enrollment within 30 days after the other coverage ends.

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

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

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

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

ANNUAL ENROLLMENT

The following rules apply to changing your health plan 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. During the annual enrollment period, you may change from your current option to any

other Plan option.

c. If you are currently enrolled in a Plan option and do not actively enroll or waive coverage during open enrollment, your Plan option and coverage level [Colleague only, Colleague + Child(ren), Colleague + Spouse/LDA, or Colleague + Spouse/LDA + Child(ren)] will continue at the new year's contribution 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.

MOVING INTO/OUT OF WISCONSIN

Moving Out of Wisconsin

If you are enrolled in one of the HSHS Wisconsin Healthy Plan options and change your primary home residence from Wisconsin to a location that is not within Wisconsin, you and all of your covered Dependents will automatically be enrolled in the corresponding option and same coverage level under the terms outlined in this HSHS Healthy Plan Summary Plan Description (SPD).

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

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

Moving Into Wisconsin

If you are enrolled in a Healthy Plan option under the terms outlined in this Summary Plan Description and your primary home residence changes to one in Wisconsin, you and all of your covered Dependents will automatically be enrolled in the corresponding option and same coverage level under the terms outlined in the Wisconsin Healthy Plan Summary Plan Description. Coverage for you and all of your covered Dependents under the terms outlined in this SPD will terminate.

You can request documentation from Aetna of the Plan Year deductible and out-of-pocket amounts you and your covered Dependents have accrued under the terms of this SPD by contacting Aetna Member Services at 1-800-345-9474 or the HSHS Colleague Service Center at 1-855-394-4747 or fyi@hshs.org. See the HSHS Wisconsin Healthy Plan SPD for the

process to follow to have these amounts credited to the HSHS Wisconsin Healthy Plan option to which you are transferred.

THE COST OF YOUR COVERAGE

You and your employer share the cost of coverage under the Plan. Your contributions for coverage will be deducted from your paycheck on a before-tax basis under Flexplan, except in situations where you are automatically enrolled in the Basic option, or you are covering an LDA who is not a federal tax dependent. If you are automatically enrolled in the Basic option because you do not provide proof of other coverage, your contributions will be deducted from your paycheck after-tax. If you are covering 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 of 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 health care benefits may have a slight effect on the benefits you and your family will receive from Social Security at retirement or in the event of your disability or death. Social Security amounts are determined using a formula that takes your F.I.C.A. taxable income into account. When you convert a portion of your pay with salary reduction, you reduce your F.I.C.A. taxable income proportionately.

FAMILY LEAVE OR MEDICAL LEAVE

If a Covered Person who is a Subscriber is on a family leave or medical leave of absence, coverage will continue 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 colleague rate for health insurance for a maximum of 26 weeks. Following that period, the Colleague may continue coverage under the Plan's ***Continuation of Coverage*** provisions.

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

For a Colleague on an unpaid approved general leave of absence, in accordance with the Plan Sponsor's policy on general leaves of absence, coverage will 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 Healthy Plan on the date the individual becomes an HSHS Colleague, provided that:

(1) the Colleague meets the Plan's eligibility requirements, other than the Plan's employment period requirement,
(2) there is no lapse in employment between the entity being acquired and the Affiliate, and
(3) the individual was *actively at work* on the last day that the acquired entity was in existence and is either:
    (a) present on his/her first scheduled work day with the HSHS Affiliate or
    (b) absent from work on his/her first scheduled work day with HSHS due to his/her own illness or Injury or due to a leave qualified under the Family and Medical Leave Act of 1993 (FML) or a leave period required by applicable state law.

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

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

If a business that HSHS acquires sponsors a group health plan that provides medical and/or prescription drug benefits on the date immediately preceding the HSHS acquisition date (*acquired entity's plan*), the following provisions apply to individuals enrolled in the *acquired entity's plan* as of the last day of the acquired entity's existence that lose access to that coverage who are not otherwise eligible to participate in the HSHS Healthy Plan:

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

employee of the acquired entity or a dependent child, the individual may enroll in HSHS Healthy Plan ***Continuation of Coverage*** for up to the lesser of:

(1) 18 months or
(2) 29 months if the individual is Social Security disabled as of the acquisition date or becomes Social Security disabled within 60 days of the acquisition date.

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

C. If the individual is an employee of the acquired entity that is off work due to his or her own illness or Injury on the last day the acquired entity is in existence and the individual has been off work for this reason for less than 26 weeks, the individual may enroll in HSHS Healthy Plan coverage as of the acquisition date:

(1) For the remainder of the 26 week period, if any, from the first day of absence due to personal illness or Injury (including the time off work under the prior entity) provided that he or she pays the premium contribution amount that applies to active employees of the HSHS Affiliate.
(2) Once 26 weeks from the first day of absence due to personal illness or Injury (including the time off work under the prior entity) has elapsed, provided that the individual has maintained coverage throughout the entire period he or she has been absent from work due to his or her personal illness or Injury, the HSHS Healthy Plan's ***Continuation of Coverage*** provisions apply.

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

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

(1) For the remainder of the FML or state leave period, if any, provided that he or she pays the premium contribution amount that applies to active employees of the HSHS Affiliate.
(2) Once the FML or state leave period has expired, provided that the individual has maintained coverage throughout the entire qualified leave period, the HSHS Healthy Plan's ***Continuation of Coverage*** provisions apply.

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

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

meets the ***Dependent Eligibility*** provisions of this Plan.

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

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

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

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

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

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

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

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

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

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

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

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

UTILIZATION REVIEW

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

PRE-CERTIFICATION REQUIRED

Certain services require precertification by Aetna. Network providers will be responsible for obtaining necessary precertification for you. Since precertification is the Network Provider's responsibility, there is no additional out-of-pocket cost to you as a result of a Network Provider's failure to pre-certify services. When you go to an Out-of-Network Provider, your Out-of-Network Provider or you must obtain precertification from Aetna. It is your responsibility to ensure either you or your Out-of-Network Provider obtains precertification from Aetna for any services or supplies on the precertification list below. If you do not pre-certify, your benefits may be reduced, or the plan may not pay any benefits.

The Utilization Review Program requires a review of the following Covered Services **before** such services are rendered:

- Stays in a hospital
- Stays in a skilled nursing facility
- Stays in a rehabilitation facility
- Stays in a hospice facility
- Corneal transplant surgery
- Outpatient hospice care
- Stays in a Residential Treatment Facility for treatment of mental disorders and substance abuse
- Partial Hospitalization Programs for mental disorders and substance abuse
- Home health care
- Private duty nursing care
- Intensive Outpatient Programs for mental disorders and substance abuse
- Applied Behavioral Analysis
- Neuropsychological testing
- Outpatient detoxification
- Psychiatric home care services
- Psychological testing

Precertification should be secured within the timeframes specified below. To obtain precertification, call Aetna at the telephone number listed on your ID card. This call must be made:

For non-emergency admissions:	You, your Physician or the facility will need to call and request precertification at least 14 days before the date you are scheduled to be admitted.
For an emergency Outpatient medical condition:	You or your Physician should call prior to the Outpatient care, treatment or procedure if

	possible; or as soon as reasonably possible.
For an emergency admission:	You, your Physician or the facility must call within 48 hours or as soon as reasonably possible after you have been admitted.
For an urgent admission:	You, your Physician or the facility will need to call before you are scheduled to be admitted. An urgent admission is a Hospital admission by a Physician due to the onset of or change in an illness; the diagnosis of an illness; or an Injury.
For Outpatient non-emergency medical services requiring precertification:	You or your Physician must call at least 14 days before the Outpatient care is provided, or the Treatment or procedure is scheduled.

Aetna will provide a written notification to you and your Physician of the precertification decision. If your precertified expenses are approved the approval is good for 60 days as long as you remain enrolled in the Plan.

When you have an Inpatient admission to a facility, Aetna will notify you, your Physician and the facility about your precertified length of stay. If your Physician recommends that your stay be extended, additional days will need to be certified. You, your Physician, or the facility will need to call Aetna at the number on your ID card as soon as reasonably possible, but no later than the final authorized day. Aetna will review and process the request for an extended stay. You and your Physician will receive a notification of an approval or denial.

If precertification determines that the stay or services and supplies are not Covered Expenses, the notification will explain why and how Aetna's decision can be appealed. You or your Physician may request a review of the precertification decision pursuant to the appeals procedures in the Claim Filing and Appeals Procedures section of this SPD.

A precertification benefit reduction will be applied to the benefits paid if you fail to obtain a required precertification prior to incurring medical expenses. This means Aetna will reduce the amount paid towards your coverage, or your expenses may not be covered. You will be responsible for the unpaid balance of the bills. The precertification benefit reduction is 30%.

Pre-certification review is not a guarantee of benefits. Actual availability of benefits is subject to eligibility and the other terms, conditions, limitations, and exclusions of the Healthy Plan.

The final decision regarding Treatment and hospitalization is yours.

LENGTH OF STAY/SERVICE REVIEW

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

Upon completion of the preadmission or emergency review, the Claim Administrator will notify your Physician and/or the Hospital confirming that you or your representative called the Claim Administrator and that an approved length of service or length of stay was assigned.

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

CASE MANAGEMENT

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

Case managers are also available to you to provide assistance when you need alternative benefits. Alternative benefits will be provided only so long as the Claim Administrator determines that the alternative services are Medically Necessary and cost–effective. The total maximum payment for alternative services shall not exceed the total benefits for which you would otherwise be entitled under the Plan.

Provision of alternative benefits in one instance shall not result in an obligation to provide the same or similar benefits in any other instance. In addition, the provision of alternative benefits shall not be construed as a waiver of any of the terms, conditions, limitations, and exclusions of the Plan.

MEDICALLY NECESSARY DETERMINATION

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

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

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

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

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

UTILIZATION REVIEW PROCEDURE

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

1. The name of the attending and/or admitting Physician;
2. The name of the Hospital and/or the location where the service has been scheduled;
3. The scheduled admission and/or service date; and
4. A preliminary diagnosis or reason for the admission and/or service.

Upon receipt of the required information, the Claim Administrator will:

- review the information provided and seek additional information as necessary,
- issue a determination as to whether the services are Medically Necessary or are not, and
- provide notification of the determination.

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

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

Aetna
Attn: National Account CRT
P.O. Box 14463
Lexington, KY 40512
Fax: 859-455-8650

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

MEDICARE ELIGIBLE MEMBERS

The preadmission review provisions of this Utilization Review program do not apply to you if you are Medicare eligible and Medicare is primary to this Plan as outlined in the ***Coordination of Benefits*** section of this Summary Plan Description.

VOLUNTARY SECOND SURGICAL OPINION

The Plan covers an additional surgical opinion following a recommendation for elective Surgery. A second opinion helps you decide whether to have surgery or choose alternative Treatment.

Your benefits will be limited to one consultation and related Diagnostic Service by a Physician. Benefits for an additional surgical opinion consultation and related Diagnostic Service will be provided at 100% of the Covered Services. Your Medical Deductible will not apply to this benefit. If you request, benefits will be provided for an additional consultation when the need for Surgery, in your opinion, is not resolved by the first arranged consultation.

The final decision of undergoing Surgery and the selection of a Physician to perform Surgery is entirely up to the Covered Person.

COVERED SERVICES

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

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

Acupuncture – when performed by a Physician and when Medically Necessary for:

- chronic low back or neck pain,
- chronic headache,
- nausea of pregnancy,
- pain from osteoarthritis of the knee or hip,
- post-operative and chemotherapy induced nausea and vomiting,
- post-operative dental pain, or
- Temporomandibular disorders

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

Ambulance – Professional ambulance services for the following are covered if Medically Necessary:

- To the first Hospital where treatment is given in a Medical Emergency.
- From one Hospital to another Hospital in a Medical Emergency when the first Hospital does not have the required services or facilities to treat your condition.
- From Hospital to home or to another facility when other means of transportation would be considered unsafe due to your medical condition.
- From home to Hospital when other means of transportation would be considered unsafe due to your medical condition.
- When during a covered inpatient stay at a Hospital, Skilled Nursing Facility or acute rehabilitation Hospital, an ambulance is required to safely and adequately transport you to or from inpatient or outpatient medically necessary treatment.

Transportation by air or rail is also covered provided:

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

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

Air ambulance requires prior authorization.

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

Amino Acid–Based Elemental Formulas - Benefits will be provided for amino acid–based

elemental formulas for the diagnosis and treatment of eosinophilic disorders or short–bowel syndrome, when the prescribing Physician has issued a written order stating that the amino acid–based elemental formula is Medically Necessary.

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

Applied Behavioral Analysis (ABA) Therapy for the Treatment of Autism Spectrum Disorder(s) when prescribed, provided or ordered for an individual diagnosed with an Autism Spectrum Disorder by:

- a Physician or a Psychologist who has determined that such care is Medically Necessary, or
- a certified, registered or licensed health care professional with expertise in treating Autism Spectrum Disorder(s) and when such care is determined to be Medically Necessary and ordered by a Physician or psychologist.

A. *Criteria for Initial Therapy* (all criteria must be met)

1. There must be a diagnosis of an Autism Spectrum Disorder
2. The maladaptive target behavior must be severe (risk to personal safety, or the safety of others in the child's environment, or very significantly/completely interferes with ability to function)
3. Parent/caregiver(s) must be involved in training of behavioral techniques
4. There is a time limited, individualized treatment plan with objective measures and describing behavioral interventions
5. There is involvement of community resources (such as the school district)
6. Services must be provided by individuals licensed by the state or certified by the Behavior Analyst Certifying Board

B. *Process for Authorization of Services*

1. ABA Provider must request authorization of services from the Claim Administrator
2. ABA Provider performs a functional analysis, develops treatment plan and submits to Claim Administrator
3. Claim Administrator reviews the functional assessment to substantiate the appropriateness of ABA Therapy.

C. *ABA Advocate Services* – A dedicated single point of contact to help you and your family will be available to assist with the following:

1. Addressing questions about autism benefits, and the ABA authorization process,
2. Finding providers,
3. Resolving claims issues,
4. Assuring treatment is effective,
5. Connecting parents to all available resources (ReThink, AbilTo, EAP, Medical, community based, educational),
6. Coordinating with integrated Autism Care providers and supports

D. *Criteria to continue therapy* – Every 6 months the ABA Provider and the Autism Advocate will review the following:
    1. The frequency of the target behavior has diminished since the last review, or if not, there has been modification of the treatment or new assessments have been conducted.
    2. Parent(s) and caregiver(s) have received retraining on these changed approaches

The treatment plan documents a gradual tapering of higher intensity intervention and a shifting to supports from other sources.

Attention Deficit Disorder (ADD)

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

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

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

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

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

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

Chemotherapy

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

Cochlear Implants - uniaural and binaural cochlear implants are covered for individuals age 18

and older with bilateral, pre- or post-linguistic, sensorineural, moderate to profound hearing impairment if medically necessary as defined by the Claim Administrator. For individuals under age 18, cochlear implants are covered for individuals with bilateral sensorineural hearing impairment if medically necessary as defined by the Claim Administrator.

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

Compression Stockings – with a Physician's prescription, if individually fitted, pre-made or custom-made pressure gradient support stockings that have a pressure of 18mm Hg or more and require measurement and fitting.

Contraceptives - Benefits will be provided for Prescription contraceptive drugs, devices, injections, implants and contraceptive services ***only when Medically Necessary***. Birth control drugs, devices, injections, or implants whether or not dispensed by Prescription, which are purchased or prescribed ***for the sole purpose of preventing conception are not covered***.

Coordinated Home Health Care - Medically Necessary part-time or intermittent nursing care by, or under the supervision of, a registered nurse (R.N.), and associated supplies, furnished in the patient's home. If an R.N. is not available, services can be provided by an L.P.N. Up to 120 visits in a calendar year are covered under the Plan.

Covered Services also include part-time or intermittent medical social services by a social worker when provided in conjunction with and in direct support of care by a R.N. or L.P.N.

Each home health aide visit for a Covered Person will be considered one home health care visit.

Dental Treatment or Service - Only the following are covered:

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

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

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

Electroconvulsive Therapy

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

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

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

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

If you receive care from an Out-of-Network Provider, your coverage for those services ends when the Claim Administrator and the attending physician determine that you are medically able to travel or be transported to a Network Provider if you need more care. If you require follow-up care and receive the care from an Out-of-Network Provider, the services will be covered at the Out-of-Network payment level.

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

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

Extended Care Facility Services - see Skilled Nursing Facility Care.

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

Hearing (or Audiology). Routine hearing screenings are covered under the ***Wellness and Preventive Care*** provisions of the Plan. Additionally, Medically Necessary hearing testing and Treatment are covered.

Hospice Care - Covered Expenses include charges made by the following furnished to you for hospice care when given as part of a hospice care program.

- Facility Expenses
    - The charges made by a hospital, hospice or skilled nursing facility for:
    - Room and Board and other services and supplies furnished during a stay for pain control and other acute and chronic symptom management; and
    - Services and supplies furnished to you on an outpatient basis.
- Outpatient Hospice Expenses - Covered Expenses include charges made on an outpatient basis by a Hospice Care Agency for:
    - Part-time or intermittent nursing care by a R.N. or L.P.N. for up to eight hours a day;
    - Part-time or intermittent home health aide services to care for you up to eight hours a day;
    - Medical social services under the direction of a physician. These include but are not limited to assessment of your social, emotional and medical needs, and your home and family situation, identification of available community resources, and assistance provided to you to obtain resources to meet your assessed needs.
    - Physical and occupational therapy;
    - Consultation or case management services by a physician;
    - Medical supplies;
    - Prescription drugs;
    - Dietary counseling; and
    - Psychological counseling.

Charges made by the providers below if they are not an employee of a Hospice Care Agency; and such Agency retains responsibility for your care:

- A physician for a consultation or case management;
- A physical or occupational therapist;
- A home health care agency for:
    - Physical and occupational therapy;
    - Part time or intermittent home health aide services for your care up to eight hours a day;
    - Medical supplies;
    - Prescription drugs;
    - Psychological counseling; and
    - Dietary counseling.

Unless specified above, not covered under this benefit are charges for:

- Daily room and board charges over the semi-private room rate;

- Funeral arrangements;
- Pastoral counseling;
- Financial or legal counseling, including estate planning and the drafting of a will; and
- Homemaker or caretaker services. These are services which are not solely related to your care. These include, but are not limited to: sitter or companion services for either you or other family members; transportation; maintenance of the house.

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

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

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

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

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

See the ***Utilization Review*** section.

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

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

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

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

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

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

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

Benefits will be provided for any Hospital length of stay in connection with childbirth for the mother or newborn child for no less than 48 hours following a normal vaginal delivery, or no less than 96 hours following a cesarean section. Your Provider will not be required to obtain authorization from the Claim Administrator for a length of stay 48 hours or less (or 96 hours or less in the case of cesarean section.)

Medical Supplies and Medical Equipment

a. Surgical dressings, supplies, casts, splints, trusses, and crutches.
b. Oxygen and rental of equipment for its administration.
c. Rental (up to the purchase price) or at the Member's option (if less expensive), the purchase of Durable Medical Equipment required for therapeutic use provided that this equipment is primarily and customarily used to serve a medical purpose. Examples of Durable Medical Equipment include wheelchairs, Hospital beds, iron lung or other respiratory paralysis equipment, and kidney dialysis equipment. Maintenance and repairs needed due to misuse or abuse are not covered.
d. Prosthetic devices, special appliances, and surgical implants when:
   - Required to replace all or part of an organ or tissue of the human body, or
   - Required to replace all or part of the function of a non-functioning or malfunctioning organ or tissue.

   Benefits include adjustments, repair and replacements of covered prosthetics devices, special appliances and surgical implants when required because of wear or change in a patient's condition (excluding dental appliances other than intra-oral devices used in connection with the Treatment of Temporomandibular Dysfunction and related disorders, subject to specific limitations applicable to Temporomandibular Dysfunction and related disorders, and replacement of cataract lenses when a prescription change is not required). Prosthetics include, but are not limited to, artificial arm, leg, hip, knee or eye, external breast prosthesis after a mastectomy, breast implant after a mastectomy, and ostomy supplies.
e. Insulin pump and insulin pump supplies.
f. First pair of frames and lenses or contact lenses following cataract surgery with a letter of Medical Necessity or if a cataract surgery claim is on file with the Claims Administrator.
g. Leg, arm, back, and neck braces only if required because of Injury or Sickness.
h. Internal cardiac valves, pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates and any other internal and permanent devices.

i. Wigs when your hair loss is due to chemotherapy, radiation therapy, or alopecia. Benefits for wigs are limited to one per calendar year.

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

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

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

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

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

Benefits will be provided for transportation and lodging for the patient and a companion. Transportation and lodging expenses for visits to the Provider prior to Surgery are covered. For transportation and lodging benefits to be available, your place of residency must be more than 50 miles from the HSHS Facility where the bariatric Surgery will be performed.

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

Covered transportation and lodging expenses related to bariatric Surgery at an HSHS Facility should be submitted to the HSHS Colleague Service Center. The HSHS Colleague Service Center will forward the expenses to Aetna for processing.

Facility expenses for bariatric Surgery are only covered if the surgery is performed at an HSHS Facility.

The following are not covered*:*

- Surgical management of obese individuals that do not meet the Plan's coverage criteria.
- Weight loss drugs regardless of whether a Prescription Drug or over-the-counter drug.
- Facility charges for bariatric Surgery if not performed at an HSHS Facility.

When Medically Necessary, repeat surgical procedures for the Treatment of Morbid Obesity are covered when ALL of the following criteria are met:

- The Covered Person met all of the requirements of this Plan at the time the original surgery

was performed,

- The Covered Person has been compliant with a prescribed nutrition and exercise program following the original surgery, AND
- Significant complications or technical failure (e.g., break down of gastric pouch, slippage, breakage or erosion of gastric band, bowel obstruction, staple line failure, etc.) of the bariatric surgery has occurred that requires take down or revision of the original procedure that could only be addressed surgically, AND
- The bariatric surgical modality meets generally accepted clinical guidelines.

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

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

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

Nurse Practitioners and Physician Assistants Services for medical care and Treatment, provided the services are within the scope of the Provider's professional license and are otherwise covered by the Plan.

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

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

Organ Transplants - Your benefits for certain human organ transplants are the same as your benefits for any other condition. Benefits will be provided only for kidney, bone marrow, heart valve, muscular–skeletal, parathyroid, heart, lung, heart/lung, liver, pancreas or pancreas/kidney human organ or tissue transplants. Benefits are available to both the recipient and donor of a covered transplant as follows:

- If you are the recipient of the transplant, and the donor for the transplant has no coverage from any other source, the benefits described in this SPD will be provided for both you and the donor. In this case, payments made for the donor will be charged against your benefits.

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

Benefits will be provided for:

- Inpatient and Outpatient services related to the transplant Surgery;
- the evaluation, preparation and delivery of the donor organ;

- the removal of the organ from the donor; and
- the transportation of the donor organ to the location of the transplant Surgery. Benefits will be limited to the transportation of the donor organ in the United States or Canada.

In addition to the above provisions, benefits for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants will be provided as follows:

- Whenever a heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplant is recommended by your Physician, you must contact the Claim Administrator by telephone before your transplant Surgery has been scheduled. The Claim Administrator will furnish you with the names of Hospitals which have Claim Administrator approved Human Organ Transplant Programs. No benefits will be provided for heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.
- If you are the recipient of the transplant, benefits will be provided for transportation and lodging for you and a companion. If the recipient of the transplant is a covered dependent child under age 19, benefits for transportation and lodging will be provided for the transplant recipient and two companions. For transportation and lodging benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
  - You and your companion are each entitled to benefits for lodging up to a separate maximum of $50 per day.
  - Benefits for transportation and lodging are limited to a combined lifetime maximum of $5,000.

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

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

Orthotics including foot orthotics, corrective shoes, and custom molded inserts and/or shoes when Medically Necessary.

Oxygen and its administration**.**

Palliative Care for the control of symptoms related to a diagnosis if Medically Necessary. Palliative Care is care that is provided to control pain and relieve symptoms, but is not meant to cure the illness.

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

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

Physician Consultations – Consultations requested by your Physician of another Physician in the diagnosis or Treatment of a condition that requires special skill or knowledge. However, Benefits are not provided for a consultation done because of Hospital regulations or by a Physician who

also renders Surgery or maternity services during the same Hospital Inpatient admission.

Physician Visits – including:

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

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

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

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

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

The term Covered Prescription Drugs means:

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

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

- birth control drugs or devices, whether or not dispensed by prescription, which are purchased or prescribed for the sole purpose of preventing conception;
- drugs used for cosmetic purposes (including, but not limited to, Retin–A/Tretinoin and Minoxidil/Rogaine);
- drugs used for the Treatment of infertility;
- drugs for which there is an over–the–counter product available with the same active ingredient(s);

- drugs which are not self–administered;
- medicinal marijuana;
- any devices or appliances except as specifically mentioned above;
- any charges that you may incur for the drugs being administered to you.

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

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

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

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

Radiation Therapy by x-ray, gamma ray, accelerated particles, mesons, neutrons, radium and radioactive isotopes.

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

Residential Treatment Center Services that are not Custodial Services.

Shingles Vaccine – Shingles vaccines approved by the federal Food and Drug Administration will be covered pursuant to the terms in the ***Wellness and Preventive Care*** section.

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

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

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

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

Substance Abuse Rehabilitation Treatment - Benefits for all of the Covered Expenses

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

Surgery - Benefits are available for Surgery performed by a Physician, dentist or podiatrist. However, for services performed by a dentist or podiatrist, benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under this Plan had they been performed by a Physician. Only those oral surgery procedures specified in Dental Treatment or Service in this section are covered.

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

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

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

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

COORDINATION OF BENEFITS

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

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

This Plan always pays secondary to any medical payment, PIP, or no-fault coverage under any automobile policy available to you and any plan or program which is required by law. All Covered Persons should review their automobile insurance policy to ensure that uncoordinated medical benefits have been chosen so that the automobile insurance policy is the primary payer.

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

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

BENEFIT DETERMINATION RULES

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

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

the person for whom a claim is made for the longer period of time will be determined before a plan which has covered the person for the shorter period of time; except that:

a. The benefits of a plan which covers the person as a laid-off or retired employee, or his dependent will be determined after a plan which covers the person as an employee, other than a laid-off or retired employee, or his dependent.

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

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

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

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

MEDICARE SECONDARY PAYER LAWS

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

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

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

employment status."

2. In the case of individuals age 65 or over, GHPs of employers that employ 20 or more employees if that individual or the individual's spouse (of any age) has "current employment status."
3. In the case of disabled individuals under age 65, GHPs of employers that employ 100 or more employees, if the individual or a member of the individual's family has "current employee status."

Your MSP Responsibilities

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

Benefits For Medicare Eligible Covered Persons not Subject to MSP Laws

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

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

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

COORDINATION WITH THE HSHS DENTAL PLAN

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

Please request that your Provider submit Claims for these services to Aetna.

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

EXCLUSIONS AND LIMITATIONS

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

- Abortions, sterilizations, elective sterilization reversal, sexual reassignment, in-vitro fertilization, artificial insemination, or embryonic implantation procedures.
- Allergy: Specific non-standard allergy services and supplies, including but not limited to, skin titration (Rinkel method), cytotoxicity testing (Bryan's Test) treatment of non-specific candida sensitivity, and urine autoinjections.
- Any expenses where there is no legal obligation or financial liability to pay or would have no legal obligation to pay if you did not have this coverage. If a Provider limits charges to those paid by this Plan, those charges are not covered by this Plan.
- Any Treatment or service which is covered by no-fault (automobile) state provisions or other similar legislation.
- Any Treatment or service not prescribed by a medical professional operating within the scope of their license in the state in which services are received.
- Any Treatment or service provided by a member of the immediate family (Member, spouse, child, brother, sister, or parent of the Member or Member's spouse).
- Any Treatment, confinement, services, or supplies if the expense is incurred by a patient covered under an HMO provided by the patient's employer.
- Any Treatment or service which is compensated for or furnished by the Federal, state, or local governments, whether or not payments or benefits are received. This exclusion shall not apply to medical assistance benefits under Article V or VI of the Illinois Public Aid Code (305 ILCS 5/5–1 et seq. or 5/6–1 et seq.) or similar legislation of any state, benefits provided in compliance with the Tax Equity and Fiscal Responsibility Act or as otherwise provided by law.
- Any Treatment or service resulting from Sickness which is covered by a Worker's Compensation Act or other similar legislation; or due to Injury incurred as the result of, or in the course of, any employment for wage or profit including self-employment.
- Birth control drugs, devices, injections, or implants whether or not dispensed by Prescription, purchased or prescribed for the sole purpose of preventing conception.
- Blood derivatives which are not classified as drugs in the official formularies.
- Charges for failure to keep a scheduled visit or charges for completion of a claim form.
- Complications resulting from an excluded service, except for complications resulting from a health care service, supply or drug that is the subject of a clinical trial.
- Cosmetic Prescription Drugs.
- Cosmetic surgery and related services and supplies, including Prescription Drugs, except for the correction of congenital deformities or conditions resulting from accidental injuries, scars, tumors or diseases.
- Procurement or use of prosthetic devices, special equipment and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the Treatment of disease or Injury.
- Expenses for Injuries sustained while committing or attempting to commit a criminal act:
  - involving the illegal use of drugs or alcohol, including but not limited to driving while

under the influence of an illegal substance or alcohol as defined by the state in which the offense took place; or
  - involving violence or the threat of violence to another person; or
  - in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Covered Person.
- Any Treatment or service for Sickness or Injury resulting from participation in a riot, insurrection, or in the commission of an assault or felony.
- Custodial Care.
- Dental Treatment or service, except as specified in ***Covered Services***.
- Diagnostic testing that is part of a survey or research study or that is Investigational.
- Education or training.
- Experimental and/or Investigational Services and Supplies.
- Routine foot care, including trimming of corns, calluses, or toenails, except for persons diagnosed with diabetes.
- Any charges which exceed Eligible Charges.
- Services or supplies received from an employee health clinic or a similar person or group.
- Glasses (frames and lenses) and contact lenses (except for Treatment of cataracts), eye examinations or Treatment of a refractive error for the correction of vision or fitting of glasses, laser eye (Lasik) surgery, orthoptics, visual training, or vision therapy.
- Hearing aids and examinations for the prescription or fitting of hearing aids.
- Heart, lung, heart/lung, liver, pancreas or pancreas/kidney transplants performed at any Hospital that does not have a Claim Administrator approved Human Organ Transplant Program.
- The following Home Health Care Agency services:
  - Food, food supplements (except for sustaining life), home delivered meals;
  - Transportation expenses;
  - Nursing care except as specified in the ***Covered Services*** section;
  - Maintenance Therapy;
  - Custodial Care;
  - Housekeeping services.
- Hospitalization when it is not Medically Necessary. A hospitalization is not Medically Necessary when, in the reasonable medical judgment of the Claim Administrator, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital or some other setting without adversely affecting the patient's condition. Examples of hospitalization services that are not Medically Necessary include:
  - Hospital admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department.
  - Hospital admissions primarily for diagnostic studies (x–ray, laboratory and pathological services and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office.

- Continued Inpatient Hospital care, when the patient's medical symptoms and condition no longer require their continued stay in a Hospital.
- Hospitalization or admission to a Skilled Nursing Facility, nursing home or other facility for the primary purposes of providing Custodial Care Service, convalescent care, rest cures or domiciliary care to the patient.
- Hospitalization or admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable.

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

- Inpatient Private Duty Nursing Services.
- Long Term Care Services.
- Maintenance Care.
- Maintenance Therapy except as specifically provided in the ***Covered Services*** section.
- Marriage counseling.
- Any Treatment, service, device or supply solely to increase or decrease height or alter rate of growth.
- Any Treatment, service, or supply that is not Medically Necessary or does not meet accepted standards of medical practice.
- Personal hygiene, comfort, or convenience items such as air conditioners, humidifiers, physical fitness equipment, televisions and telephones.
- Private Duty Nursing Services during a period in which the individual is receiving Home Health Care Agency services.
- Respite Care Services, except as specifically provided for Hospice Care.
- Services and supplies received prior to your Coverage Date.
- Services and supplies received after your coverage termination date.
- Services or supplies received during an Inpatient stay when the stay is primarily related to behavioral, social maladjustment, lack of discipline or other antisocial actions which are not specifically the result of Mental Illness. This exclusion does not apply to services or supplies provided for the Treatment of an Injury resulting from an act of domestic violence or a medical condition (including both physical and mental health conditions).
- Speech Therapy when rendered for the Treatment of psychosocial speech delay, behavioral problems (including impulsive and impulsivity syndrome), attention disorder, conceptual handicap or mental disability with the exception of covered ABA therapy for autism spectrum disorders.
- Surrogate motherhood expenses, including maternity services rendered to a Covered Person who becomes pregnant as a Gestational Surrogate under the terms of, and in accordance with, a Gestational Surrogacy Contract or any other arrangement. This applies to all surrogate motherhood expenses associated with conception, birth and recovery from childbirth, including, but not limited to the following: in vitro, prenatal, maternity/obstetrics care, and child birth/delivery health care services rendered to the Covered Person, acting as a Gestational Surrogate.
- Any non-surgical Treatment of temporomandibular joint syndrome (TMJ).

- Travel, other than transportation by designated emergency vehicle, unless otherwise specified, whether or not recommended by a Physician.
- Any treatment or service received outside of the USA other than care to treat a Medical Emergency or Emergency Accident and care required to treat an unexpected episode of illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care.
- Any Treatment or service resulting from war or any act of war, declared or undeclared.
- Marijuana, even if medicinal and prescribed by a Physician.
- Whirlpools, portable whirlpools, sauna baths, and elevators.
- Treatment of impulse control disorders, such as pathological gambling, kleptomania, pedophilia, caffeine or nicotine use.
- Treatment of antisocial personality disorder.
- Treatment in wilderness programs or other similar programs.
- Disposable outpatient supplies such as bags, elastic garments, bedpans, compresses and other devices not intended for reuse by another patient.
- Alternative/complementary medicine services will be excluded, including but not limited to: aromatherapy, bioenergetics therapy, carbon dioxide therapy, chelation therapy, hair analysis, hypnosis, megavitamin therapy, primal therapy, psychodrama, purging, rolfing, and thermogenic therapy.
- Facility charges for services or supplies for weight reduction by surgical method including but not limited to, gastric bypass, gastric balloon, stomach stapling, jejunal bypass, wiring of the jaw or any services of similar nature that are not performed at an HSHS Facility. Also excluded are:
  - any charges for stimulants, preparations, food or diet supplments, dietary regimens and supplements, appetite suppressants and other medications related to weight reduction or weight control,
  - exercise programs, exercise equipment, membership to health or fitness clubs, recreational therapy or other forms of activity or activity enhancement, and
  - special programs or plans for weight reduction or weight control, other than nutritional counseling services provided by a Registered Dietician (RD) under the Wellness and Preventive Care benefit of this Plan or for the Treatment of Morbid Obesity.

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

TERMINATION OF COVERAGE

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

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

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

- The date your spouse 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 expenses paid by the Plan for services incurred during periods that a dependent that you have enrolled in the Plan is not eligible to participate in the Plan.

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

CONTINUATION OF COVERAGE

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

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 health plan.

UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT OF 1994

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

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

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

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

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

CLAIM FILING AND APPEALS PROCEDURES

FILING MEDICAL SERVICE CLAIMS

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

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

If you have to file a Claim, complete a Claim Form which is available on the Claim Administrator's website (www. aetna.com), contact Aetna Member Services at the phone number of your ID card. Attach copies of all bills to be considered for benefits. These bills must include the Provider's name and address, patient's name, diagnosis, date of service, description of service and Claim Charge. Mail the completed Claim Form to the address on the Claim Form.

Under the Plan, you may file claims for Plan benefits and appeal adverse claim determinations. Any reference to "you" in this Claim Filing and Appeals section includes you and your Authorized Representative. An "Authorized Representative" is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. In the case of an urgent care claim, a health care professional with knowledge of your condition may always act as your Authorized Representative.

If your claim is denied in whole or in part, you will receive a written notice of the denial from Aetna. The notice will explain the reason for the denial and the appeal procedures available under the Plan.

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

If you have any questions about filing Claims, contact Aetna Member Services at the phone number on your ID card.

FILING OUTPATIENT PRESCRIPTION DRUG CLAIMS

In order to obtain your benefits under this Plan, it is necessary for a Claim to be filed with the Pharmacy Benefit Manager. To file a Claim, usually all you will have to do is show your ID card to the Pharmacy. They will file your Claim for you. Remember however, it is your responsibility to ensure that the necessary Claim information has been provided to the Pharmacy Benefit Manager.

If you have to file a Claim, complete a Claim Form which is available on the Pharmacy Benefit Manager's website (www.express-scripts.com/hshs). Attach copies of all receipts to be considered for benefits. These receipts must include date prescription filled, name and address of pharmacy, doctor name or ID number, NDC number (drug number), name of drug and strength, quantity and day supply, prescription number (Rx number), DAW (Dispense As Written), amount paid. Mail the completed Claim Form to the address on the Claim Form.

URGENT CARE CLAIMS

An "Urgent Care Claim" is any claim for medical care or treatment for which the application of the time periods for making non-urgent care determinations could seriously jeopardize your life or health or your ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

If the Plan requires advance approval of a service, supply or procedure before a benefit will be payable, and if Aetna or your physician determines that it is an Urgent Care Claim, you will be notified of the decision, whether adverse or not, as soon as possible but not later than 72 hours after the claim is received.

If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but not later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information, and you will be notified of the decision not later than 48 hours after the end of that additional time period (or after receipt of the information, if earlier).

OTHER CLAIMS (PRE-SERVICE AND POST-SERVICE)

If the Plan requires you to obtain advance approval of a non-urgent service, supply or procedure before a benefit will be payable, a request for advance approval is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim.

For other claims (post-service claims), you will be notified of the decision not later than 30 days after receipt of the claim.

For either a pre-service or a post-service claim, these time periods may be extended up to an additional 15 days due to circumstances outside Aetna's control. In that case, you will be notified of the extension before the end of the initial 15 or 30-day period. For example, they may be extended because you have not submitted sufficient information, in which case you will be notified of the specific information necessary and given an additional period of at least 45 days after receiving the notice to furnish that information. You will be notified of Aetna's claim decision no later than 15 days after the end of that additional period (or after receipt of the information, if earlier).

For pre-service claims which name a specific claimant, medical condition, and service or supply for which approval is requested, and which are submitted to an Aetna representative responsible for handling benefit matters, but which otherwise fail to follow the Plan's procedures for filing pre-service claims, you will be notified of the failure within 5 days (within 24 hours in the case of an urgent care claim) and of the proper procedures to be followed. The notice may be oral unless you request written notification.

ONGOING COURSE OF TREATMENT

If you have received pre-authorization for an ongoing course of treatment, you will be notified in advance if the previously authorized course of treatment is intended to be terminated or reduced so that you will have an opportunity to appeal any decision to Aetna and receive a decision on that appeal before the termination or reduction takes effect. If the course of treatment involves urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request.

HEALTH CLAIMS – STANDARD APPEALS

As an individual enrolled in the Plan, you have the right to file an appeal from an Adverse Benefit Determination relating to service(s) you have received or could have received from your health care provider under the Plan.

An "Adverse Benefit Determination" is defined as a denial, reduction, termination of, or failure to, provide or make payment (in whole or in part) for a service, supply or benefit. Such Adverse Benefit Determination may be based on:

- Your eligibility for coverage, including a retrospective termination of coverage (whether or not there is an adverse effect on any particular benefit);
- Coverage determinations, including plan limitations or exclusions;
- The results of any Utilization Review activities;
- A decision that the service or supply is Experimental or Investigational; or
- A decision that the service or supply is not Medically Necessary.

A "Final Internal Adverse Benefit Determination" is defined as an Adverse Benefit Determination that has been upheld by the appropriate named fiduciary (Plan or its designee) at the completion of the internal appeals process, or an Adverse Benefit Determination for which the internal appeals process has been exhausted.

Exhaustion Of Internal Appeals Process

Generally, you are required to complete all appeal processes of the Plan before being able to obtain External Review or bring an action in litigation. However, if Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under applicable federal law, you are considered to have exhausted the Plan's appeal requirements ("Deemed Exhaustion") and may proceed with External Review or may pursue any available remedies under state law, as applicable.

There is an exception to the Deemed Exhaustion rule. Your claim or internal appeal may not go straight to External Review if:

- A rule violation was minor and is not likely to influence a decision or harm you; and
- It was for a good cause or was beyond Aetna's or the Plan's or its designee's control; and
- It was part of an ongoing good faith exchange between you and Aetna or the Plan.
- This exception is not available if the rule violation is part of a pattern or practice of violations by Aetna or the Plan.

You may request a written explanation of the violation from the Plan or Aetna, and the Plan or Aetna must provide such explanation within 10 days, including a specific description of its bases, if any, for asserting that the violation should not cause the internal claims and appeals process to be deemed exhausted. If an External Reviewer or a court rejects your request for immediate review on the basis that the plan met the standards for the exception, you have the right to resubmit and pursue the internal appeal of the claim. In such a case, within a reasonable time after the External Reviewer or court rejects the claim for immediate review (not to exceed 10 days), you will receive notice of the opportunity to resubmit and pursue the internal appeal of the claim. Time periods for re-filing the claim shall begin to run upon your receipt of such notice.

Full and Fair Review of Claim Determinations and Appeals

The Plan or its designee will provide you, free of charge, with any new or additional evidence considered, relied upon, or generated by Aetna (or at the direction of the Plan or its designee), or any new or additional rationale as soon as possible and sufficiently in advance of the date on which the notice of Final Internal Adverse Benefit Determination is provided, to give you a reasonable opportunity to respond prior to that date.

You may file an appeal in writing to Aetna at the address provided in this booklet, or, if your appeal is of an urgent nature, you may call Aetna's Member Services Unit at the toll-free phone number on your ID card. Your request should include the group name (that is, your employer), your name, member ID, or other identifying information shown on the front of the Explanation of Benefits form, and any other comments, documents, records and other information you would like to have considered, whether or not submitted in connection with the initial claim.

An Aetna representative may call you or your health care provider to obtain medical records and/or other pertinent information in order to respond to your appeal.

You will have 180 days following receipt of an Adverse Benefit Determination to appeal the determination to Aetna. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received. You may submit written comments, documents, records and other information relating to your claim, whether or not the comments, documents, records or other information were submitted in connection with the initial claim. A copy of the specific rule, guideline or protocol relied upon in the Adverse Benefit Determination will be provided free of charge upon request by you or your Authorized Representative. You may also request that Aetna provide you, free of charge, copies of all documents, records and other information relevant to the claim.

If your claim involves urgent care, an expedited appeal may be initiated by a telephone call to the phone number included in your denial, or to Aetna's Member Services. Aetna's Member Services telephone number is on your Identification Card. You or your Authorized Representative may appeal urgent care claim denials either orally or in writing. All necessary information, including the appeal decision, will be communicated between you or your Authorized Representative and Aetna by telephone, facsimile, or other similar method. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with the appeal decision on an urgent care claim, you may file a second level appeal with the Plan or its designee. You will be notified of the decision not later than 36 hours after the appeal is received.

If you are dissatisfied with a pre-service or post-service appeal decision, you may file a second level appeal with the Plan or its designee within 60 days of receipt of the level one appeal decision. Send your appeal request to Aetna and Aetna will forward your appeal request and any additional information you have provided, along with the level one appeal file, to the Plan or its designee. The Plan or its designee will notify you of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

If you do not agree with the Final Internal Adverse Benefit Determination on review, you have the right to bring a civil action.

HEALTH CLAIMS – VOLUNTARY APPEALS

External Review

"External Review" is a review of an eligible Adverse Benefit Determination or a Final Internal Adverse Benefit Determination by an Independent Review Organization/External Review Organization (ERO) or by the State Insurance Commissioner, if applicable.

A "Final External Review Decision" is a determination by an ERO at the conclusion of an External Review.

You must complete all of the levels of standard appeal described above before you can request External Review, other than in a case of Deemed Exhaustion. Subject to verification procedures that the Plan may establish, your Authorized Representative may act on your behalf in filing and pursuing this voluntary appeal.

You may file a voluntary appeal for External Review of any Adverse Benefit Determination or any Final Internal Adverse Benefit Determination that qualifies as set forth below.

The notice of Adverse Benefit Determination or Final Internal Adverse Benefit Determination that you receive from the Plan or its designee will describe the process to follow if you wish to pursue an External Review, and will include a copy of the Request for External Review Form.

You must submit the Request for External Review Form to Aetna within 123 calendar days of the date you received the Adverse Benefit Determination or Final Internal Adverse Benefit Determination notice. If the last filing date would fall on a Saturday, Sunday or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or Federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

If you file a voluntary appeal, any applicable statute of limitations will be tolled while the appeal is pending. The filing of a claim will have no effect on your rights to any other benefits under the Plan. However, the appeal is voluntary and you are not required to undertake it before pursuing legal action.

If you choose not to file for voluntary review, the Plan will not assert that you have failed to exhaust your administrative remedies because of that choice.

Request for External Review

The External Review process under this Plan gives you the opportunity to receive review of an Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) conducted pursuant to applicable law. Your request will be eligible for External Review if the claim decision involves medical judgment and the following are satisfied:

- Aetna, or the Plan or its designee, does not strictly adhere to all claim determination and appeal requirements under federal law (except for minor violations); or
- the standard levels of appeal have been exhausted; or
- the appeal relates to a rescission, defined as a cancellation or discontinuance of coverage which has retroactive effect.

An Adverse Benefit Determination based upon your eligibility is not eligible for External Review.

If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for External Review, you will be informed in writing of the steps necessary to request an External Review.

An independent review organization refers the case for review by a neutral, independent clinical reviewer with appropriate expertise in the area in question. The decision of the independent external expert reviewer is binding on you, Aetna and the Plan unless otherwise allowed by law.

Preliminary Review

Within 5 business days following the date of receipt of the request, the Plan or its designee must provide a preliminary review determining: you were covered under the Plan at the time the service was requested or provided, the determination does not relate to eligibility, you have exhausted the internal appeals process (unless Deemed Exhaustion applies), and you have provided all paperwork necessary to complete the External Review and you are eligible for external review.

Within one business day after completion of the preliminary review, the Plan or its designee must issue to you a notification in writing. If the request is complete but not eligible for External Review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan or its designee must allow you to perfect the request for External Review within the 123 calendar days filing period or within the 48 hour period following the receipt of the notification, whichever is later.

Referral to ERO

The Plan or its designee will assign an ERO accredited as required under federal law, to conduct the External Review. The assigned ERO will timely notify you in writing of the request's eligibility and acceptance for External Review, and will provide an opportunity for you to submit in writing within 10 business days following the date of receipt, additional information that the ERO must consider when conducting the External Review. Within one (1) business day after making the decision, the ERO must notify you, Aetna and the Plan.

The ERO will review all of the information and documents timely received. In reaching a decision, the assigned ERO will review the claim and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned ERO, to the extent the information or documents are available and the ERO considers them appropriate, will consider the following in reaching a decision:

(i) Your medical records;

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

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or issuer, you, or your treating provider;

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

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

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

(vii)The opinion of the ERO's clinical reviewer or reviewers after considering the information

described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.

The assigned ERO must provide written notice of the Final External Review Decision within 45 days after the ERO receives the request for the External Review. The ERO must deliver the notice of Final External Review Decision to you, Aetna and the Plan.

After a Final External Review Decision, the ERO must maintain records of all claims and notices associated with the External Review process for six years. An ERO must make such records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where such disclosure would violate State or Federal privacy laws.

Upon receipt of a notice of a Final External Review Decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review

The Plan must allow you to request an expedited External Review at the time you receive:

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

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

Immediately upon receipt of the request for expedited External Review, the Plan or its designee will determine whether the request meets the reviewability requirements set forth above for standard External Review. The Plan or its designee must immediately send you a notice of its eligibility determination.

Referral of Expedited Review to ERO

Upon a determination that a request is eligible for External Review following preliminary review, the Plan or its designee will assign an ERO. The ERO shall render a decision as expeditiously as your medical condition or circumstances require, but in no event more than 72 hours after the ERO receives the request for an expedited External Review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned ERO must provide written confirmation of the decision to you, Aetna and the Plan.

PAYMENT OF CLAIMS AND ASSIGNMENT OF BENEFITS

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

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

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

GENERAL INFORMATION and NOTICES

RIGHT TO AMEND OR TERMINATE THE PLAN

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

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Covered Person in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan′s Claims Administrator - Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayment they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

SUBROGATION AND RIGHT OF RECOVERY

The provisions of this section apply to all current or former Covered Persons and also to the parents, guardian, or other representative of a dependent child who incurs Claims and is or has been covered by the Plan. The Plan's right to recover (whether by subrogation or reimbursement) shall apply to the personal representative of your estate, your decedents, minors, and incompetent or disabled persons. "You" or "your" includes anyone on whose behalf the plan pays benefits. No adult Covered Person hereunder may assign any rights that it may have to recover medical expenses from any tortfeasor or other person or entity to any minor child or children of said adult covered person without the prior express written consent of the Plan.

The Plan's rights of subrogation and reimbursement, as set forth below, extend to all insurance coverage available to you due to an Injury, illness or condition for which you received Plan benefits (including, but not limited to, liability coverage, uninsured motorist coverage, underinsured motorist coverage, personal umbrella coverage, medical payments coverage, workers compensation coverage, no fault automobile coverage or any first party insurance coverage).

The Plan is always secondary to automobile no-fault coverage, personal injury protection coverage, or medical payments coverage.

No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Subrogation

The right of subrogation means the Plan is entitled to pursue any claims that you may have in order to recover the benefits paid by the Plan. Immediately upon paying or providing any benefit under the Plan, the Plan shall be subrogated to (stand in the place of) all of your rights of recovery with respect to any claim or potential claim against any party, due to an Injury, illness or condition to the full extent of benefits provided or to be provided by the Plan. The Plan may assert a claim or file suit in your name and take appropriate action to assert its subrogation claim, with or without your consent. The Plan is not required to pay you part of any recovery it may obtain, even if it files suit in your name.

Reimbursement

If you receive any payment as a result of an Injury, illness or condition, you agree to reimburse the Plan first

from such payment for all amounts the Plan has paid and will pay as a result of that Injury, illness or condition, up to and including the full amount of your recovery.

Constructive Trust

By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an Injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the Plan. No disbursement of any settlement proceeds or other recovery funds from any insurance coverage or other source will be made until the Plan's subrogation and reimbursement interest are fully satisfied.

Lien Rights

Further, the Plan will automatically have a lien to the extent of benefits paid by the Plan for the treatment of the Illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, Injury or condition for which the Plan paid benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the Plan including, but not limited to, you, your representative or agent, and/or any other source that possessed or will possess funds representing the amount of benefits paid by the Plan.

Assignment

In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

First-Priority Claim

By accepting benefits from the Plan, you acknowledge that the Plan's recovery rights are a first priority claim and are to be repaid to the Plan before you receive any recovery for your damages. The Plan shall be entitled to full reimbursement on a first-dollar basis from any payments, even if such payment to the Plan will result in a recovery which is insufficient to make you whole or to compensate you in part or in whole for the damages sustained. The Plan is not required to participate in or pay your court costs or attorney fees to any attorney you hire to pursue your damage claim.

Applicability to All Settlements and Judgments

The terms of this entire subrogation and right of recovery provision shall apply and the Plan is entitled to full recovery regardless of whether any liability for payment is admitted and regardless of whether the settlement or judgment identifies the benefits the Plan provided or purports to allocate any portion of such settlement or judgment to payment of expenses other than medical expenses. The Plan is entitled to recover from any and all settlements or judgments, even those designated as pain and suffering, non-economic damages and/or general damages only. The Plan's claim will not be reduced due to your own negligence.

Cooperation

You agree to cooperate fully with the Plan's efforts to recover benefits paid. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, of your intention to pursue or investigate a claim to recover damages or obtain compensation due to your Injury, illness or condition. You and your agents agree to provide the Plan or its representatives notice of any recovery you or your agents obtain prior to receipt of such recovery funds or within 5 days if no notice was given prior to receipt. Further, you and your agents agree to provide notice prior to any disbursement of settlement or any other recovery funds obtained. You and your agents shall provide all information requested by the Plan, the Claims Administrator or its representative including, but not limited to, completing and submitting any applications or other forms or statements as the Plan may reasonably request and all documents related to or filed in personal injury litigation. Failure to provide this information, failure to assist the Plan in pursuit of its subrogation rights or failure to reimburse the Plan from any settlement or recovery you receive may result in the denial of any future benefit payments or claim until the Plan is reimbursed in

full, termination of your benefits or the institution of court proceedings against you.

You shall do nothing to prejudice the Plan's subrogation or recovery interest or prejudice the Plan's ability to enforce the terms of this Plan provision. This includes, but is not limited to, refraining from making any settlement or recovery that attempts to reduce or exclude the full cost of all benefits provided by the Plan or disbursement of any settlement proceeds or other recovery prior to fully satisfying the Plan's subrogation and reimbursement interest.

You acknowledge that the Plan has the right to conduct an investigation regarding the Injury, illness or condition to identify potential sources of recovery. The Plan reserves the right to notify all parties and his/her agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

You acknowledge that the Plan has notified you that it has the right pursuant to the Health Insurance Portability & Accountability Act ("HIPAA"), 42 U.S.C. Section 1301 et seq, to share your personal health information in exercising its subrogation and reimbursement rights.

Interpretation

In the event that any claim is made that any part of this subrogation and right of recovery provision is ambiguous or questions arise concerning the meaning or intent of any of its terms, the Claims Administrator for the Plan shall have the sole authority and discretion to resolve all disputes regarding the interpretation of this provision.

Jurisdiction

By accepting benefits from the Plan, you agree that any court proceeding with respect to this provision may be brought in any court of competent jurisdiction as the Plan may elect. By accepting such benefits, you hereby submit to each such jurisdiction, waiving whatever rights may correspond by reason of your present or future domicile. By accepting such benefits, you also agree to pay all attorneys' fees the pPan incurs in successful attempts to recover amounts the Plan is entitled to under this section

YOUR PROVIDER RELATIONSHIPS

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

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

The use of an adjective such as Network, Participating, Preferred, Administrator or approved in modifying a Provider shall in no way be construed as a recommendation, referral or any other statement as to the ability or quality of such Provider. In addition, the omission, non–use or non–designation of Participating, Administrator,

approved or any similar modifier or the use of a term such as Out-of-Network, Non–Administrator, or Non–Participating should not be construed as carrying any statement or inference, negative or positive, as to the skill or quality of such Provider.

NOTICES

Any information or notice which you furnish to the Claim Administrator under the Plan as described in this SPD must be in writing and sent to the Claim Administrator at PO Box 981106, El Paso, Texas 79998-1106(unless another address has been stated in this SPD for a specific situation). Any information or notice which the Claim Administrator furnishes to you must be in writing and sent to you at your address as it appears o n the Claim Administrator's records or in care of your Plan Sponsor and if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Claim Administrator's records.

LIMITATIONS OF ACTIONS

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

INFORMATION AND RECORDS

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

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

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

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

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

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT

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

Provider obtain authorization from the Plan for prescribing a length of stay not in excess of 48 hours (or 96 hours).

IMPORTANT INFORMATION

Name of Plan:
The HSHS Healthy Plan

Health Plan Identifier (HPID): 7881697081

Plan Sponsor:
Hospital Sisters Health System

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

PARTICIPATING EMPLOYERS:

- St. Elizabeth's Hospital
  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
- Hospital Sisters Health System (HSHS)
  Springfield, Illinois
- St. Clare Hospital
  Oconto Falls, Wisconsin
- Prairie Education & Research Cooperative
  Springfield, Illinois

APPENDIX A

HSHS FACILITIES

Covered Services for Facility services and supplies (those services and supplies billed on a UB form) received from the following will be covered by the Plan at the HSHS Facility benefit level:

St. Elizabeth's Hospital (EIN-37-0663567)
211 South Third Street
Belleville, IL 62222
618-234-2120

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

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

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

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

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

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

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

Good Shepherd Hospital (EIN-37-0512290)
200 South Cedar Street
Shelbyville, IL 62565
(217) 774-3961

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

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

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

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

St. Clare Memorial Hospital (EIN-39-0848401)
855 S. Main St.
Oconto Falls, WI 54154
920-846-3444

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

Surgery Center of Sheboygan, LLC
(EIN-39-0808480)
3141 Saemann Avenue
Sheboygan, WI 53081
920-783-5000

HSHS Medical Group, Inc. (Illinois)
EIN-26-3956318

HSHS Wisconsin Medical Group, Inc.
EIN-26-4515959

NOTICE OF PRIVACY PRACTICES

Effective 01/01/2019

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

WHO WILL FOLLOW THIS NOTICE?

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

OUR PLEDGE REGARDING YOUR PHI

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

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

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

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

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

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

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

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

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

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

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

and development, business management and general administrative activities.

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

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

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

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

USES AND DISCLOSURE FOR HEALTH-RELATED BENEFITS OR SERVICES

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

USES AND DISCLOSURES REQUIRED BY LAW

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

DISCLOSURES FOR HEALTH OVERSIGHT ACTIVITIES

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

DISCLOSURES FOR LAWSUITS AND DISPUTES

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

DISCLOSURES TO LAW ENFORCEMENT

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

DISCLOSURES TO PLAN SPONSOR

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

DISCLOSURES FOR WORKERS COMPENSATION

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

YOUR RIGHTS REGARDING PHI ABOUT YOU

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

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

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

Right to Request Restrictions. You have the right to request we restrict the use of your PHI for Treatment, payment and health care operations. ***We are not required to agree to your request.*** If we do agree, we will comply with your request unless the information is needed to provide you emergency Treatment under the HSHS Plan. To request restrictions, you must make your request in writing to your 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 Humana 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.

HSHS

Colleague Service Center

Benefit Questions?
1-855-FYI-HSHS