

Ascension SmartHealth Medical Plan

Summary Plan Description

Revised January 1, 2023

myAscension
benefits



Ascension

Plan Outline and Schedules of Benefits

Daughters of Charity Ministries, Inc. | Ascension SmartHealth Medical Plan | St. Louis, MO

Revision Date	January 1, 2023
Participating Employers	<p>The Plan has been adopted by Daughters of Charity Ministries, Inc.</p> <ul style="list-style-type: none">• Daughters of Charity Ministries – Evansville Campus• Daughters of Charity Ministries – St. Louis Campus• Daughters of Charity Ministries Albany Campus• Daughters of Charity Ministries Emmitsburg Campus
Eligible Associates	<p>Active full-time and part-time Associates who are budgeted and working at least 24 hours per week.</p> <p><u>Special Rule:</u> PRN and temporary associates may be eligible to participate in the Plan under a pay-all option.</p>
Entry Date	The first day of the month coinciding with or immediately following date of hire.
Your Cost for Coverage	You share in the cost of coverage through Participant Contributions as well as flat dollar Copays, Deductibles, and a Cost-Share percentage when you receive care.
Schedule(s) of Benefits (Medical)	<p>Daughters of Charity Ministries, Inc. offers the following option to Eligible Associates. You may elect the following Schedule of Benefits (named to indicate the level of benefits provided through the Ascension Network level of benefits):</p> <ul style="list-style-type: none">• SmartHealth PPO Copay Plan. <p>The Schedule of Benefits give you access to the Ascension Network, National Network (BCBS), and Out of Network benefit levels (see the Schedule(s) of Benefits on the following pages).</p>
Claims Administrator	Automated Benefit Services, Inc.
Care Management	Ascension Care Management LLC
Schedule of Benefits (Prescription Drug)	SmartHealth Rx
Pharmacy Benefit Claims Administrator (Non-Ascension Pharmacies)	Cigna

Pharmacy Benefit Claims Administrator (Ascension Pharmacies)	Ascension Rx Pharmacy
Mail Order Claims Administrator	Ascension Rx Home Delivery
Specialty Medication Claims Administrator	Ascension Rx Specialty Pharmacy
Plan Year	Plan records are administered on a calendar-year basis beginning January 1 and ending December 31 of each year.

Associates from other Ascension ministries also participate in this plan and each Health Ministry has a separate Summary Plan Description (SPD) for its associates. For a complete list of participating employers, please visit www.mysmarthealth.org.

2023 Schedule of Benefits: PPO Copay Plan

Benefits	Ascension Network Tier 1	National Network Tier 2	Out-of-Network ⁽¹⁾ Tier 3
Deductible <ul style="list-style-type: none"> Individual Family <small>*All eligible expenses apply toward all Deductibles</small>	\$0 \$0	\$3,000 \$6,000	\$5,000 \$10,000
Coinsurance <ul style="list-style-type: none"> Plan Pays You Pay 	100% 0%	60% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Total Out-Of-Pocket Maximum (Deductible plus coinsurance and copays) <ul style="list-style-type: none"> Individual Family <small>*All eligible expenses apply toward all OOP Maximums</small>	\$3,000 \$6,000	\$9,100 \$18,200	\$12,500 \$25,000
Lifetime Maximum	Unlimited	Unlimited	Unlimited

Services	Ascension Network Tier 1	National Network Tier 2	Out-of-Network ⁽¹⁾ Tier 3
Preventative Services Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/ Annual Mammogram Screening, Colonoscopy	\$0	\$0	50% after Deductible
Facility Outpatient/ Diagnostic Services <small>(per provider/per day³)</small> Radiology, CT Scans, Radiation & Chemotherapy, Diagnostic Infertility Testing, Labs, Ultrasounds (non-Maternity)	\$75 Copay	40% after Deductible	50% after Deductible
Medical Specialty (Physician administered or infusion therapy) <ul style="list-style-type: none"> Physician office/home Outpatient 	Prior Authorization Required \$150 Copay ⁽²⁾ \$300 Copay ⁽²⁾	Prior Authorization Required 40% after Deductible ⁽²⁾ 40% after Deductible ⁽²⁾	Prior Authorization Required 50% after Deductible ⁽²⁾ 50% after Deductible ⁽²⁾
Outpatient Surgery/Facility Charge Anesthesia, Ancillary Services, Pathology, Physician Charges & Surgery	\$500 Copay	40% after Deductible	50% after Deductible
Outpatient Surgery/Physician's Office	\$75 Copay	40% after Deductible	50% after Deductible
Physical/Occupational/Speech Therapy <small>(Annual maximum for PT, OT, ST - 60 visits combined)</small> <ul style="list-style-type: none"> Occupational & Speech Therapy Physical Therapy 	\$25 Copay (OT and ST) \$10 Copay (PT)	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Dialysis (per treatment)	\$25 Copay	\$25 Copay	50% after Deductible

2023 Schedule of Benefits: PPO Copay Plan

AHMSC, AHSCM, AHIS, ALBIR, ALMOB, ARDCS, DCWAS, FLJAC, FLPEN, ININD, INMXL, KSWIC, MDBAL, MIDET, MIGRA, MIKAL, MIROC, MODCM, MOSET, MOSTL, TNNAS, TXAUS, TXDCS, TXWAC, WIAPP, WIMIL
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Chiropractic Visit (Annual maximum - 35 visits) Note: Includes manipulation and therapy; x-rays excluded	\$30 Copay	40% after Deductible	50% after Deductible
Facility High Tech Radiology (non-emergent) (per visit unless otherwise noted) Example: MRI and PET scans)	Prior Authorization Required \$500 Copay ⁽²⁾	Prior Authorization Required 40% after Deductible ⁽²⁾	Prior Authorization Required 50% after Deductible ⁽²⁾
Office Visits (per visit unless otherwise noted) Primary Care (Family Practice/ General Internal Medicine/ Pediatrics)	\$25 Copay	40% after Deductible	50% after Deductible
Specialist (including OB/GYN)	\$50 Copay	40% after Deductible	50% after Deductible
Amwell Online Care <ul style="list-style-type: none"> Behavioral Health Online Visit Urgent Care Online Visit 	\$25 Copay \$0 copay	N/A N/A	N/A N/A
All other E-Visits <ul style="list-style-type: none"> Primary Care Specialist 	\$25 Copay \$50 Copay	40% after Deductible 40% after Deductible	50% after Deductible 50% after Deductible
Pre/Postnatal Care & Delivery	\$50 Copay (Once per pregnancy)	40% after Deductible	50% after Deductible
<ul style="list-style-type: none"> Maternity Imaging (Ultrasound) 	\$75 Copay to maximum of \$150 Copay (per pregnancy)	40% after Deductible	50% after Deductible
Mental Health (per visit unless otherwise noted) <ul style="list-style-type: none"> Individual Therapy/ Group Therapy E-Visits Partial Day Treatment/ Intensive Outpatient Therapy Inpatient Admission (Annual maximum - 120 days) 	\$25 Copay \$25 Copay \$200 Copay \$200 Copay	\$25 Copay \$25 Copay \$200 Copay \$200 Copay	50% after Deductible
Substance Use Disorder (per visit unless otherwise noted) <ul style="list-style-type: none"> Individual Therapy/ Group Therapy E-Visits Partial Day Treatment/ Intensive Outpatient Therapy Acute Inpatient Care (Annual maximum - 120 days) 	\$25 Copay \$25 Copay \$200 Copay \$200 Copay	\$25 Copay \$25 Copay \$200 Copay \$200 Copay	50% after Deductible
Emergency Care (per visit unless otherwise noted) <ul style="list-style-type: none"> ER Visit 	\$500 Copay (Waived if admitted)	\$500 Copay (Waived if admitted)	\$500 Copay (Waived if admitted)
<ul style="list-style-type: none"> Urgent Care 	\$75 Copay	\$200 Copay after Deductible	\$200 Copay after National Network Deductible
<ul style="list-style-type: none"> Ambulance 	\$200 Copay	\$200 Copay	\$200 Copay
<ul style="list-style-type: none"> Medical Transfer/ Transport (non-emergent) 	Prior Authorization Required \$200 Copay ⁽²⁾	Prior Authorization Required \$200 Copay ⁽²⁾	Prior Authorization Required \$200 Copay ⁽²⁾
Inpatient Services (per admission) Room and Board, Ancillary Services, Surgery, Anesthesia, Physician Charges	Prior Authorization Required \$750 Copay ⁽²⁾	Prior Authorization Required 40% after Deductible ⁽²⁾	Prior Authorization Required 50% after Deductible ⁽²⁾

2023 Schedule of Benefits: PPO Copay Plan

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Inpatient Admission through Emergency Room	\$750 Copay	40% after Deductible	40% after National Network Deductible
Allergy Testing & Treatment	\$25 Copay (per visit)	40% after Deductible (per visit)	50% after Deductible (per visit)
Extended Care Facility (per admission) (Annual maximum - 120 days)	\$500 Copay	40% after Deductible	50% after Deductible
Home Health Care (Annual maximum - 100 visits)	\$50 Copay (per day)	40% after Deductible (per day)	50% after Deductible (per day)
Hospice	\$500 Copay	40% after Deductible	50% after Deductible
Other Services (per provider/ per day) • Durable Medical Equipment (DME)	Prior Authorization Required 10% Copay (Annual out of pocket maximum \$250) ⁽²⁾	Prior Authorization Required 40% after Deductible ⁽²⁾	Prior Authorization Required 50% after Deductible ⁽²⁾
Prosthetics & Orthotics (P&O) (per provider/per day)	\$200 Copay	40% after Deductible	50% after Deductible
Foot Orthotics (2 pairs every 3 years)	\$100 Copay (per pair)	50% after Deductible (per pair)	50% after Deductible (per pair)
Hearing Aid (3-year maximum - \$2,000)	\$200 Copay	40% after Deductible	50% after Deductible
Bariatric Surgery	Prior Authorization Required See Inpatient Services ⁽²⁾	Prior Authorization Required See Inpatient Services ⁽²⁾	Prior Authorization Required See Inpatient Services ⁽²⁾
Organ/Bone Marrow/Other Transplants	Prior Authorization Required See Inpatient Services ⁽²⁾	Prior Authorization Required See Inpatient Services ⁽²⁾	Prior Authorization Required See Inpatient Services ⁽²⁾
Wellness/ Disease Management (Diabetic Education per Medicare guidelines)	\$0	\$0	50% after Deductible
Smoking Cessation Intervention (Counseling)	\$0	\$0	50% after Deductible

***Notes:** (1) Any claim incurred through an Out-of-Network provider could result in balance billing and/or additional charges to the member. (2) Prior Authorization Required - failure to secure a Prior Authorization for certain services may result in no coverage/benefit paid under the Plan. To review a complete and up-to-date list of those services which require Prior Authorization, go to www.mysmarthealth.org. All inpatient admissions require a Prior Authorization, failure to secure a Prior Authorization for an inpatient admission may result in a reduction of benefits under the Plan. (3) The Ascension network includes all Health Ministries of Ascension - over 36,000 aligned providers in 2,600+ sites of care - including 139 hospitals and more than 39 senior living facilities in 19 states and the District of Columbia. (4) In some instances when services are unavailable from an Ascension Network provider, members may obtain services from a National Network provider and such services will be processed at the Ascension Network benefit level. Benefit Elevation is required in order to obtain such National Network benefits at the Ascension Network benefit level. For more information on the required Benefit Elevation process, go to www.mysmarthealth.org. (5) Separate provider copays may apply.

Exclusions - See the SmartHealth Medical Summary Plan Description at www.mysmarthealth.org for complete information regarding exclusions.

Prescription Drugs - Go to www.mysmarthealth.org/pharmacy for details about your Health Ministry's prescription drug benefits.

The U.S. Department of Health and Human Services, the Department of Labor, and the Internal Revenue Service have jointly released final regulations regarding women's preventative services under the Affordable Care Act ("ACA"). The ACA requires group health plans to provide coverage for "contraceptive services" as part of an array of women's preventative services that must be included in health plans without cost sharing to covered participants. The regulations contain an accommodation for eligible non-profit religious organizations that oppose providing contraceptive coverage. As a health ministry of the Catholic Church, Ascension Health Alliance d/b/a Ascension does not promote or condone contraceptive practices and objects to providing such coverage. Therefore, as the Plan Sponsor of the self-funded Ascension SmartHealth Medical Plan ("Plan"), which includes prescription drug benefits, Ascension qualifies as an eligible organization that is entitled to the accommodation. As a result, the Plan does not provide coverage for contraceptive benefits that are in conflict with our Catholic Identity and the Ethical and Religious Directives for Catholic Health Care Services. As part of the accommodation, third party administrators of the Plan are required to provide this coverage to covered members at no cost, independently of Ascension and consistent with the authority given them by the final regulations. You will receive information directly from those administrators about the coverage that may be available to you for those "preventative services."

This is a brief summary of benefits, which is subject to change. To resolve any conflict between this summary and the Summary Plan Description, you should consult the Plan document, which will prevail over both this summary and the Summary Plan Description. For further details about plan benefits, please contact Customer Service at the number shown on the back of your ID card, or view the official Summary Plan Description at www.mysmarthealth.org.

2023 Schedule of Benefits: PPO Copay Plan

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2023 Schedule of Benefits: Rx

Prior Authorization Required?	Yes - when applicable. Refer to current formulary.
Quantity Level Limits	Yes
Out of Pocket Limits	Applies to PPO Plan Participants \$3,000 per individual/ \$6,000 per family
Mandatory Generic Provision	Yes. If you choose to receive a preferred brand drug when a generic drug is available, your costs will be equal to the generic copayment plus the difference between the generic and the preferred brand drug.
Mandatory Specialty Provision	For more information, please visit www.mysmarthealth.org/pharmacy
Ascension Rx (30 day supply)	Generic: Up to \$15 copay Preferred Brand: 20% (minimum \$30/ maximum \$50) Non-Preferred Brand: 30% (minimum \$50/ maximum \$100) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: \$10 copay
Ascension Rx (90 day supply)	Generic: Up to \$30 copay Preferred Brand: 20% (minimum \$60/ maximum \$100) Non-Preferred Brand: 30% (minimum \$125/ maximum \$250) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: \$25 copay
Retail Benefit (30 day supply)	Generic: Up to \$15 copay Preferred Brand: 25% (minimum \$50/ maximum \$100) Non-Preferred Brand: 35% (minimum \$60/ maximum \$120)
Ascension Rx Home Delivery (90 day supply)	Generic: Up to \$30 copay Preferred Brand: 20% (minimum \$60/ maximum \$100) Non-Preferred Brand: 30% (minimum \$125/ maximum \$250) Ascension Preferred Diabetic Supplies (Strips/Lancets)/ Insulin: \$25 copay
Ascension Rx Specialty Pharmacy (30 day supply)	Preferred Brand: \$200 copay Non-Preferred Brand: \$200 copay
Pharmacy Benefit Manager (PBM)	Cigna
Mail Order Benefit Manager	Ascension Rx Home Delivery
Specialty Drug Benefit Manager	Ascension Rx Specialty Pharmacy

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Your Contact Information

For Questions About Eligibility	Your Human Resources department	
For Questions About Benefits, Claims and How the Plan Works	Automated Benefit Services, Inc. (ABS) To speak with a customer service representative, call 888-492-6811. 8 a.m.-7 p.m. Eastern (7 a.m.-6 p.m. Central), Monday-Friday. For 24/7 automated call services, call 888-494-4600.	
To Find a Physician or Hospital	Go online to https://mysmarthealth.org/ and select Find a Doctor or see the <i>Tier Coverage</i> section of the Information Center .	
To Request Prior Authorization (Physicians only)	Ascension Insurance Utilization Management Gateway <i>(through eQHealth Solutions)</i> 8440 Jefferson Hwy Suite 101 Baton Rouge, LA 70809 Phone: 866-356-3666; Fax: 586-693-4768 8 a.m.-6 p.m. Eastern (7 a.m.-5 p.m. Central), Monday-Friday	
To File a Medical Claim	Ascension Network Claims Automated Benefit Services for SmartHealth P. O. Box 37705 Oak Park, MI 48237-7705 EDI Payer #38259	National Network or Out-of-Network Claims File with local Blue Cross Blue Shield using the three-letter alpha prefix on your SmartHealth ID card.

<p>To Appeal a Pre-Service, Concurrent Care or Time-Sensitive Medical Claim</p>	<p>Level 1 Appeal <u>Medical Necessity Determinations</u> Ascension Insurance Utilization Management Gateway <i>(through eQHealth Solutions)</i> 8440 Jefferson Hwy Suite 101 Baton Rouge, LA 70809 Phone: 866-356-3666 Fax: 586-693-4768 8 a.m.-6 p.m. Eastern (7 a.m.-5 p.m. Central), Monday-Friday</p> <p><u>Administrative (Non-Medical Necessity) Determinations</u> Automated Benefit Services for SmartHealth P. O. Box 321125 Detroit, MI 48232 Phone: 888-492-6811 or 888-494-4600 (automated) Fax: 586-238-4363</p>	<p>Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363</p>
<p>To Appeal a Post-Service Medical Claim</p>	<p>Level 1 Appeal SmartHealth Appeals Committee P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363</p>	<p>Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363</p>
<p>To Appeal a Non-Covered Benefit Medical Claim</p>	<p>Level 1 Appeal SmartHealth Appeals Committee P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363</p>	<p>Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363</p>
<p>For Questions About Prescription Drug Coverage</p>	<p>Cigna 855-281-8312 Representatives are available 24 hours a day, seven days a week.</p>	

To Find an Ascension Rx Pharmacy Near You	Go to https://ascensionrx.com/ and click on “Find an Ascension Rx retail pharmacy.”	
For Questions About 90-Day Maintenance Medications through Ascension Rx Home Delivery	Ascension Rx Home Delivery 833-633-7279 Representatives are available 9 a.m.-6 p.m. Eastern (8 a.m.-5 p.m. Central), Monday-Friday https://ascensionrx.com/	
For Questions About Specialty Medications	Ascension Rx Specialty Pharmacy 855-292-1427 Representatives are available 9 a.m.-6 p.m. Eastern (8 a.m.-5 p.m. Central), Monday-Friday https://ascensionrx.com/	
To Appeal Claims Involving Retail Pharmacy Drugs, Ascension Rx Pharmacy Drugs and Ascension Rx Maintenance Medications	Level 1 Appeal Cigna Appeals Unit Attn: Appeals Coordinator P.O. Box 188011 Chattanooga, TN 37422	Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363
To Appeal a Pre-Service or Time-Sensitive Medical Specialty Drug Claim	Level 1 Appeal <u>Medical Necessity Determinations</u> Ascension RX Specialty Pharmacy <i>(through eQHealth Solutions)</i> Attn: Medical Specialty Drugs 8440 Jefferson Hwy Suite 101 Baton Rouge, LA 70809 Phone: 866-356-3666 Fax: 586-693-4768 8 a.m.-6 p.m. Eastern (7 a.m.-5 p.m. Central), Monday-Friday	Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363
To Appeal a Post-Service Medical Specialty Drug Claim	Level 1 Appeal SmartHealth Appeals Committee Attn: Medical Specialty Drugs P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363	Level 2 Appeal (Voluntary) SmartHealth Advisory Committee Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363

To Request an External Review (Medical and Prescription Drug Claim Denials)	SmartHealth Attn: Appeals Department P.O. Box 321125 Detroit MI, 48232 Fax: 586-238-4363
To File a Change of Address or Other Change (for example, the birth of a child)	Your Human Resources department
For Questions (including Current Balances) About Your Health Reimbursement Arrangement (HRA), Health Savings Account (HSA) and/or Flexible Spending Account (FSA)	Optum Financial Call 844-594-1231 to speak with a customer service representative. https://myoptumfinancial.com/ascension
To File an HRA, HSA or FSA Claim	Optum Financial Claims Department P.O. Box 622317 Orlando, FL 32862-2317
For COBRA Information	COBRA Administrator WEX Health Inc. 855-828-8826 https://www.wexinc.com/

Associates from other Ascension Healthcare Ministries also participate in the Plan and each Health Ministry has a separate Summary Plan Description (“SPD”) for its associates. For a complete list of participating employers, please visit <https://mysmarthealth.org/>.

Contents

The *Plan Outline* at the beginning of this SPD includes requirements and provisions that apply specifically to your Health Ministry. The *Schedule(s) of Benefits*, *Your Contact Information*, and the remainder of this SPD summarize Plan provisions that generally apply to all Health Ministries that offer the Plan.

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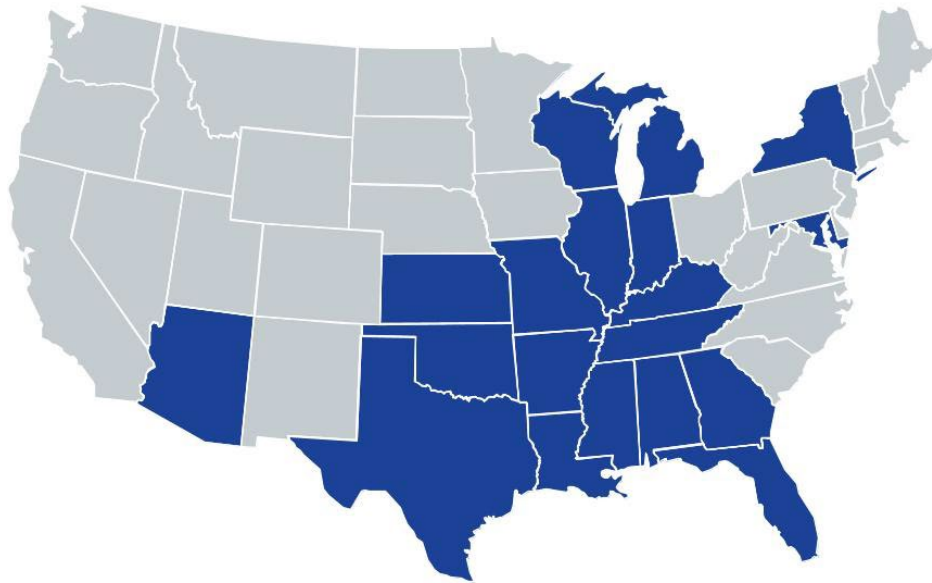
Section 1: Introduction

Ascension (to include its subsidiaries*) is a faith-based healthcare organization dedicated to transformation through innovation across the continuum of care. Our Mission is to serve all people, with special attention to those who are poor and vulnerable.

We recognize that the individuals who work in our ministries are the primary means by which our Mission is accomplished. Ascension is committed to building a community of associates who are respected, recognized and rewarded, and a culture of health and well-being focused on the whole person. The Ascension SmartHealth Medical Plan (“Plan” or “SmartHealth”) has been developed to help achieve these goals.

You and your covered dependents have access to the compassionate, personalized care Ascension is known for -- not only in your local ministry, but also from every Ascension provider and facility across the U.S. Although you may receive care from any licensed provider, using Ascension Network providers means that you receive the highest level of benefits coverage, as well as the support of Ascension’s continuum of care.

This Summary Plan Description (“SPD”) provides important information about your SmartHealth medical and prescription drug coverage.



**Ascension Healthcare’s Mission-focused Health Ministries employ approximately 139,000 associates serving in more than 2,600 sites of care in 19 states and the District of Columbia.*

Our Philosophy of Health and Well-Being

We know that it takes energy, time and effort to maintain or improve your health. SmartHealth provides a foundation to support you in taking charge of your overall well-being. The focus is not on achieving perfect health but on taking steps to become as well as you possibly can be. As a Participant in SmartHealth, you will be encouraged to work with your doctor and SmartHealth to:

- Be good stewards of our healthcare resources by taking advantage of SmartHealth preventive care services and making informed choices for all medical care.
- Further our vision of health and well-being by taking care of your physical, social, mental, emotional and spiritual needs.



An important step is to be informed about this benefit Plan so that you can make decisions that are right for you.

Overview of the Plan

When you first become eligible to enroll in SmartHealth, Ascension HR Central will provide enrollment information that explains how to enroll, the deadline, any choices that may be available to you, and your share of the cost of coverage.

As an Eligible Associate, you may enroll yourself and any Eligible Dependents. (See the *Plan Outline* and *Schedule(s) of Benefits* at the beginning of this SPD for your Health Ministry's eligibility and participation requirements.)

If you don't enroll when first eligible, you may enroll later at the next open enrollment date (or earlier if your situation changes). You must notify Ascension HR Central of any change (marriage, birth of a child, change of address, etc.) and make related benefit election changes within 30 days of the change.

See the Glossary for Definitions of Terms

Many terms that are defined in the official Plan document are also used throughout this SPD. Other terms that are not defined in the official Plan document are used solely for purposes of this SPD. Many of these terms, which are capitalized, are defined in the Glossary provided in *Appendix I*.

Also note that "you" or "your" refers to the Eligible Associate, any Eligible Dependents, any COBRA Qualified Beneficiary, or other continuation participant covered as Participants under the Plan.

"Day" or "Days" refer to calendar day(s).

Your *Schedule of Benefits* spells out the details of your coverage. See the *Schedule(s) of Benefits* offered by your Health Ministry at the beginning of this SPD. If you are given a choice of Schedules, this means that you have an opportunity to choose whether you want to pay most of your share of costs before you need care (in payroll contributions) or when you obtain care (in out-of-pocket costs).

You and the Plan share the cost of your medical care. In addition to paying a share of the premium, you also pay amounts (shown in your *Schedule of Benefits*) when you receive care. After you satisfy any Deductible for a given Plan Year, the Plan will pay a percentage (called coinsurance or a Cost-Share percentage) of Covered Expenses during the remainder of the Plan Year. You pay the remaining Cost-Share up to the Annual Out-of-Pocket Maximum. You also pay for any costs you incur that are excluded from Covered Expenses or costs that exceed any maximums or limitations. In addition, if you utilize Out-of-Network providers, you may receive bills for charges in excess of the Maximum Payable Charge

allowed by the Plan. Benefits are subject to Maximum Payable Charge limitations, benefit maximums, exclusions and limitations. Certain services require Prior Authorization.

You do not need to select a Network or a doctor when you enroll. You choose a Network when you need care and you receive the level of benefits provided through that Network. SmartHealth offers you access to three “tiers” of providers:

- **Ascension Network** – An expanded network of Health Ministry doctors and facilities. When you use Ascension Network providers, you get better than competitive benefits – because we are a healthcare provider.
- **National Network** – The network named on your *Schedule of Benefits* which is made up of doctors and facilities who have an agreement with SmartHealth but are not affiliated with the Health Ministry. They are available because we recognize that at times you may need care that is not available from an Ascension Network provider. Although you will pay more than in the Ascension Network, SmartHealth’s National Network coverage is competitive with other employers in the same area.
- **Out-of-Network** – Other doctors and facilities who are not participating in the Ascension or National Network. Out-of-Network benefits will provide some coverage if you are not able to use an Ascension or National Network provider, but you’ll pay at least double the cost, maybe more.

The provider you choose when you need care determines how much you pay. Some services – such as preventive care services – are paid at the same level in both the Ascension and National Networks. However, for most services, if you visit an Ascension Network provider, the amount you pay will typically be at the lowest level. Also, please remember that if you visit an Out-of-Network provider, you will pay substantially more-- typically at least double the cost.

Benefit Elevation Program

The benefit elevation program was created to assist Associates who (i) live in areas where there are no Ascension Network providers/facilities available, or (ii) have other special circumstances that qualify for Benefit Elevation. If an Ascension Network provider is not available where a Participant resides, or if the other special circumstances for Benefit Elevation apply, then payment of Covered Expenses will be made at a higher Tier than would otherwise apply.

In some situations, Benefit Elevation applies automatically. In other situations, you must request benefit elevation by filling out a *Benefit Elevation Request* form. To access this form, go to <https://mysmarthealth.org/>, and after selecting your Health Ministry, click on **Information Center** and review the **Benefit Elevation** section. If Benefit Elevation Approval is required, a request for such approval must be submitted in advance or within 180 days after the date of the treatment or service for which Benefit Elevation is requested.

The following chart lists the circumstances in which Benefit Elevation may apply.

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Obstetric Services	National Network	Ascension Network	<ul style="list-style-type: none"> • Participating Employer has elected to apply this Benefit Elevation. • Participant incurs a Covered Expense from a National Network provider designated for obstetric services as provided online at https://mysmarthealth.org/. 	No
Dialysis Services	National Network	Ascension Network	<ul style="list-style-type: none"> • Participating Employer has elected to apply this Benefit Elevation. • Participant incurs a Covered Expense from a National Network provider designated for dialysis services as provided online at https://mysmarthealth.org/. 	No
Unlisted National Network Provider	N/A	National Network	<ul style="list-style-type: none"> • Participant incurs a Covered Expense from a National Network provider not designated as a National Network provider online at https://mysmarthealth.org/. 	Yes
Out of Area Benefit Elevation (National Network)	National Network	Ascension Network	<ul style="list-style-type: none"> • Participant does <u>not</u> reside in the Chicago, Illinois metropolitan area. • Participant incurs a Covered Expense from a National Network provider. • There is no Ascension Network provider licensed to provide the services for which the Covered Expense was incurred within 50 miles of the Participant's home address of record. 	Yes, unless Benefit Elevation has been applied automatically.

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Out of Area Benefit Elevation 20-Mile Rule (National Network)	National Network	Ascension Network	<ul style="list-style-type: none"> Participant resides in the Chicago, Illinois metropolitan area. Participant incurs a Covered Expense from a National Network provider. There is no Ascension Network provider licensed to provide the services for which the Covered Expense was incurred within 20 miles of the Participant's home address of record. 	Yes
Out of Area Benefit Elevation (Out-of-Network)	Out-of-Network	National Network	<ul style="list-style-type: none"> Participant incurs a Covered Expense from an Out-of-Network provider. There is no National or Ascension Network provider licensed to provide the services for which the Covered Expense was incurred within 50 miles of the Participant's home address of record. 	Yes, unless Benefit Elevation has been applied automatically.
Out-of-Network Emergency Room	Out-of-Network	National Network	<ul style="list-style-type: none"> Participant incurs Covered Expenses at an Emergency Room of an Out-of-Network Hospital. 	No
Out-of-Network Admission from Emergency Room	Out-of-Network	National Network	<ul style="list-style-type: none"> Participant incurs Covered Expenses while Hospital Confined in an Out-of-Network Hospital as the result of an admission from the Emergency Room. 	Yes
Outpatient Services Resulting from Emergency Room Visit or Admission	Out-of-Network	National Network	<ul style="list-style-type: none"> Participant incurs Covered Expenses for Outpatient services as the result an Emergency Room visit or admission (including without limitation follow-up care incurred as the result an Emergency Room visit or admission). 	Yes

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Facility Driver (Ascension Network Facility)	National Network or Out-of-Network	Ascension Network	<ul style="list-style-type: none"> • Participant incurs Covered Expenses at an Ascension Network facility. • Participant incurs associated Covered Expenses in connection with services rendered by one or more National Network and/or Out-of-Network providers at such Ascension Network facility. • Participant had no control over the selection of such provider or providers described above. • The services described above are paid as listed in the Ascension Network column of the <i>Schedule of Benefits</i>. 	No
Facility Driver (National Network Facility)	Out-of-Network	National Network	<ul style="list-style-type: none"> • Participant incurs Covered Expenses at a National Network facility. • Participant incurs associated Covered Expenses in connection with services rendered by one or more Out-of-Network providers at such National Network facility. • Participant had no control over the selection of such provider or providers described above. • The services described above are paid as listed in the National Network column of the <i>Schedule of Benefits</i>. 	No

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Radiology/ Pathology Services (Ascension Network Provider Referral)	National Network or Out-of-Network	Ascension Network	<ul style="list-style-type: none"> • Participant incurs Covered Expenses at an Ascension Network provider. • Participant incurs associated Covered Expenses in connection with radiology or pathology services (other than lab work) rendered by one or more National Network and/or Out-of-Network providers. • Participant had no control over the selection of the provider or providers described above. • The services described above are paid as listed in the National Network or Out-of-Network column of the <i>Schedule of Benefits</i>. 	No
Radiology/ Pathology Services (National Network Provider Referral)	Out-of-Network	National Network	<ul style="list-style-type: none"> • Participant incurs Covered Expenses at a National Network provider. • Participant incurs associated Covered Expenses in connection with radiology or pathology services (other than lab work) rendered by one or more Out-of-Network providers. • Participant had no control over the selection of the provider or providers described above. • The services described above are paid as listed in the Out-of-Network column of the <i>Schedule of Benefits</i>. 	No

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Facility Transfer	National Network or Out-of-Network	Ascension Network	<ul style="list-style-type: none"> Participant incurs Covered Expenses at a National Network or an Out-of-Network facility (the "Transferee Facility"). Participant was transferred or directed to the Transferee Facility from or by an Ascension Network facility (the "Transferor Facility") because the Transferor Facility either was not equipped to provide the treatment or service needed by the Participant or did not have space available for the Participant. At the time of such transfer, the Participant was either an inpatient of the Transferor Facility or was receiving care in the emergency room or department of the Transferor Facility. Transferring or directing the Participant to another Ascension Network facility would be medically inadvisable due to the distance of such other facility. 	Yes
EMS Facility Decision	National Network or Out-of-Network	Ascension Network	<ul style="list-style-type: none"> Participant incurs Covered Expenses at a National Network or an Out-of-Network facility in connection with a Medical Emergency. Participant was taken to the National Network or an Out-of-Network facility referenced above due to Medical Necessity based on an EMS decision that transport to a more distant facility could jeopardize the outcome for the Participant. 	Yes

Name of Benefit Elevation	Elevation from Tier	Elevation to Tier	Conditions for Benefit Elevation Approval (All Must be Satisfied)	Benefit Elevation Approval Required?
Acquisition of Employer	National Network	Ascension Network	<ul style="list-style-type: none"> Participant becomes a Participant in the Plan as the result of Ascension's acquisition of an employer that is a Participating Employer. Participant incurs Covered Expenses at a National Network provider or facility within 90 days after the closing date of the acquisition described above. 	No

If you qualify for a Health Benefits Subsidy, you will pay Deductibles, Copays and Cost-Shares reduced from the amounts shown in the Schedule for charges by Ascension Network providers and facilities.

In most cases, your doctor, pharmacist or other healthcare provider will obtain Prior Authorization and file claims on your behalf, but it is still your responsibility to ensure that the Prior Authorization is obtained.

All claims filed, regardless of type, must be filed with the Claims Administrator within 12 months of the date the expense was incurred. Ordinarily, claims will be processed within 30 days. We will notify you of any delay and explain any steps that you may need to take for the claim to be processed.

You will receive an explanation of any expenses that are not paid, including the amounts that are your responsibility to pay. The notice will also explain the steps you may take if you do not understand, or agree with, the payment of benefits. The notice will be mailed to your address on record.

The *Plan Outline* at the beginning of this SPD includes requirements and provisions that apply specifically to your Health Ministry. The *Schedule(s) of Benefits, Your Contact Information*, and the remainder of this SPD summarize Plan provisions that generally apply to all Health Ministries that offer the Plan.

Before leaving employment or requesting a leave of absence, discuss your benefit options with an Ascension HR Central representative. When your coverage terminates for any reason, you will receive information about continuation coverage mailed to your address on record.

Any communication addressed to you at your latest home address on file will be binding upon you for all purposes of the Plan. Be sure to file changes of address with Ascension HR Central.

This Document is a Summary

The information in this Summary Plan Description ("SPD") is intended to serve as a summary of the Ascension SmartHealth Medical Plan ("Plan" or "SmartHealth"), effective **January 1, 2023** unless otherwise provided. You should refer to the official Plan document for details. If there are any discrepancies between the information in this SPD and the official Plan document, the terms of the Plan document will control.

The information in this SPD is intended to be current as of January 1, 2023 unless otherwise provided. However, certain information changes from time to time, for example, the composition of the Ascension Network and National Network, Deductibles and Copays, covered benefits or excluded benefits. Therefore, before you seek treatment, you should ensure that you have up-to-date information by visiting <https://mysmarthealth.org/>.

This SPD does not constitute a contract of employment or a guarantee of benefits or future employment. In addition, your eligibility and participation in the Plan should not be construed as an employment contract.

Oral representations regarding the Plan will not be binding on the Plan, even if the oral representation is made by an authorized Plan representative.

Important Information Regarding Benefits Relating to COVID-19

Certain Plan provisions were modified effective as of March 15, 2020 in connection with and as a result of the COVID-19 pandemic. This section summarizes the modifications. Information in this section overrides inconsistent information in other sections of the SPD. The provisions of this section were effective from March 15, 2020 to July 1, 2023 (the “COVID-19 Coverage Period”). For more information, please call the SmartHealth Customer Service telephone number on the back of your SmartHealth ID card.

COVID-19 Covered Expenses and Exclusions

The following will apply during the COVID-19 Coverage Period:

- *Participant Cost-Sharing (i.e., Deductibles, Copays and Cost-Share)* will not apply for provider office visits, urgent care visits, emergency department visits and online care visits through Ascension Online Care related to COVID-19 diagnosis, and COVID-19 testing (including antibody testing) for all Participants enrolled in either the SmartHealth Preferred Provider Organization Plan (PPO) option or the SmartHealth High Deductible Health Plan (“HDHP”) option.
- *Online care visits* related to COVID-19 provided by Ascension Online Care will be covered with \$0 cost to SmartHealth Participants.
- *Emergency department visits* will be covered with no Participant Cost-Sharing if they result in an order for or administration of a COVID-19 test. All other emergency department visits will be covered under the present *Schedules of Benefits*.
- *Laboratory charges directly related to COVID-19 testing* (including antibody testing) will be covered with no Participant Cost-Sharing, regardless of whether the testing occurs at a physician’s office, clinic, urgent care, emergency department or another laboratory.
- *Prior Authorization* is not required for Participants to receive COVID-19 testing (including antibody testing) or inpatient treatment of COVID-19. For more information about Prior Authorization, please refer to your *Schedule of Benefits* for this Plan Year as well as <https://mysmarthealth.org/>.
- *Coverage at all Tiers.* The special COVID-19 coverage provisions described in this section are applicable to care received from an Ascension Network (Tier 1), National Network (Tier 2) or Out-of-Network (Tier 3) provider. If you receive care at a Tier 3 provider, you may receive a bill

from the provider requesting additional payment above the SmartHealth maximum payable charge. This is known as a “balance bill.” If you receive a balance bill, please contact customer service at the telephone number provided on the back of your SmartHealth ID card.

- *Prescription Drug/Pharmacy Benefits.* No changes are being made at this time to the prescription drug benefit under the Ascension Prescription Drug Plan. Participants are encouraged to consider requesting 90-day supplies of Maintenance Medications from their prescribing provider.
- *COVID-19 related claims incurred before March 15, 2020.* Any claims related to COVID-19 incurred before March 15, 2020 that meet the guidelines for coverage under this section may be considered for coverage on appeal.

Important Information Regarding Extension of Timeframes

The Plan includes a provision that implements the requirements of ERISA Section 518, which provides for the extension of the deadlines by which certain actions must be taken under certain circumstances. On May 4, 2020, the Department of the Treasury, Internal Revenue Service (“IRS”), and Department of Labor, Employee Benefits Security Administration (“EBSA”) (collectively, the “Agencies”) published a notice that provides for the extension of certain deadlines under the authority of ERISA Section 518 as a result of the COVID-19 pandemic (the “ERISA Section 518 Notice”). The extension of deadlines under the ERISA Section 518 Notice is described below.

Extension of Deadlines under the ERISA Section 518 Notice

The ERISA Section 518 Notice provides that for purposes of the following deadlines, the Plan must disregard the COVID-19 “Outbreak Period.” The “Outbreak Period” is the period from March 1, 2020 until July 10, 2023, which is 60 days after the end of the National Emergency as announced by the Agencies. Therefore, the maximum amount of time that must be disregarded under the requirements of ERISA Section 518 is the earlier of (1) one year from the original deadline date (for example, the deadline for submitting a claim or appeal or making a COBRA election), or (2) July 10, 2023. By disregarding the Outbreak Period, the Plan effectively extends the deadlines covered by the ERISA Section 518 Notice. The deadlines that may be extended are as follows:

- *COBRA Qualifying Event Notice Deadline:* The date by which covered employees and qualified beneficiaries must notify the plan of a qualifying event for COBRA continuation coverage purposes.
- *COBRA Disability Determination Notice Deadline:* The date by which covered employees and qualified beneficiaries must notify the plan of a determination of disability for COBRA continuation coverage purposes.
- *COBRA Coverage Election Deadline:* The date by which a COBRA Qualified Beneficiary must elect COBRA continuation coverage.
- *COBRA Premium Payment Deadline:* The date by which COBRA premium payments must be made (including any applicable grace period).
- *COBRA Election Notice Deadline:* The date by which the Plan must provide a COBRA election notice.
- *HIPAA Special Enrollment Period:* The date by which an individual must request coverage under the Plan under the Plan’s HIPAA Special Enrollment Period provisions.

- *Benefit Claim Deadline:* The date by which an individual may file a benefit claim under the Plan's claims procedures.
- *Appeal Deadline:* The date by which a claimant may file an appeal of an adverse benefit determination under the Plan's claim review procedures.
- *External Review Deadline:* The date by which a claimant may file a request for, or provide additional information to perfect, an external review of an adverse benefit determination under the Plan's claim review procedures.

Provisions of this SPD that relate to the foregoing deadlines are modified to the extent required by (and should be read in conjunction with) the foregoing provisions relating to the ERISA Section 518 Notice. The deadlines listed above will not be extended for circumstances that occur after July 10, 2023 (the date of the end of the Outbreak Period), and instead the applicable timeframes provided in the Plan will apply. For example, if a benefit claim is filed after July 10, 2023, deadlines applicable to the benefit claim will not be extended under this section and the benefit claim will be subject to the claims procedures deadlines in *Section 8* of this SPD.

Section 2: Eligibility and Participation

Eligibility

All Associates in your Health Ministry's class of Eligible Associates may enroll. (See the *Plan Outline and Schedule(s) of Benefits* at the beginning of this SPD for details.)

Eligible Dependents

Eligible Associates may also enroll any Eligible Dependents. You will have to provide proof of your dependents' eligibility. Eligible Dependents include the Eligible Associate's Spouse, Child (who is less than 26 years old), and/or Disabled Dependent Child.

Spouse. An Eligible Dependent includes a "Spouse," which is defined as the individual lawfully married to the Eligible Associate (even if legally separated), including an individual who is the common-law spouse of an Eligible Associate if the state in which the Eligible Associate resides recognizes common-law marriage.

Child. An Eligible Dependent includes a "Child," which is defined as an Eligible Associate's natural child, legally adopted child, child placed with the Eligible Associate for adoption, foster child, or stepchild. Also included is any child for whom the Eligible Associate has been granted full legal (both managing and possessory conservatory) custody or guardianship.

Note: A special rule applies to guardianships for purposes of the Plan. If legal (both managing and possessory conservatory) custody or guardianship ends because a Child reaches age 18 and such Child is an Eligible Dependent at the time that legal custody or guardianship ends, such Child shall continue to be deemed an Eligible Dependent until the Child attains age 26.

Disabled Dependent Child. An Eligible Dependent may also include a Disabled Dependent Child, that is, a Child age 26 or older who became *permanently and totally disabled* under the Plan prior to attainment of age 26. The Child must be:

- Unmarried,
- Receiving over one-half of the Child's support from the Eligible Associate or the Eligible Associate's Spouse, and
- Eligible to be claimed on Eligible Associate's (or the Eligible Associate's Spouse's) Federal income tax return.

A Child is "permanently and totally disabled" if the Child is unable to engage in any substantial gainful activity because of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted (or can be expected to last) for a continuous period of at least twelve months.

Note: An individual is not considered an Eligible Dependent while the individual is incarcerated in any jail, prison, correctional facility or penitentiary for longer than 30 days or for a period that the Plan Administrator anticipates will be longer than 30 days.

Legally Domiciled Beneficiary

Unless otherwise indicated in your *Plan Outline*, an Eligible Associate may also enroll a Legally Domiciled Beneficiary as defined in the *Glossary* and subject to certain Plan provisions.

- A Legally Domiciled Beneficiary does not include an Eligible Dependent or an employee of the Eligible Associate.
- An Eligible Associate may elect coverage under the Plan for only one Legally Domiciled Beneficiary at a time.
- An Eligible Associate may elect coverage under the Plan for either a Spouse or a Legally Domiciled Beneficiary – not both.

Coordination of Benefits

Benefits under this Plan may be coordinated with other coverage you may have that provide medical benefits, including other group health plans, COBRA coverage, motor vehicle accident insurance, money you receive from another person who caused an accident resulting in injury to you, and/or Medicare. Please see *Section 12* for details.

Double Eligibility

If you and your Spouse are both Eligible Associates, both of you may enroll in your own individual coverage or you may elect coverage with one as the Eligible Associate and the other as an Eligible Dependent Spouse. (You may not receive coverage as both an Eligible Associate and an Eligible Dependent Spouse at the same time.) However, only one of you may cover any Eligible Dependent Children. If you change coverage from Eligible Associate to Eligible Dependent Spouse, or vice versa, during the Plan Year, any Covered Expenses paid will automatically transfer for the purpose of meeting Deductibles, annual maximums and Cost-Sharing requirements.

If you and your Dependent Child are both Eligible Associates, each of you may enroll in your own individual coverage or you may elect coverage together as the Eligible Associate and Dependent Child.

Enrollment

You will have an opportunity to enroll during the initial enrollment period when you first become eligible, during the next open enrollment period, during a special enrollment period, or after a Change Event.

Initial Enrollment Period

When an Associate first becomes an Eligible Associate, the Associate will be provided with enrollment information that explains all of the steps required to enroll the Eligible Associate and any Eligible Dependents. The information will include any forms or address for online access to the forms as well as the deadline date for enrolling.

If the Eligible Associate enrolls by the deadline, the Associate and Eligible Dependents will become Participants on the Entry Date specified by the Health Ministry. (See the *Plan Outline and Schedule(s) of Benefits* at the beginning of this SPD.)

Enroll on Time

If you fail to enroll by the deadline date stated in your enrollment information, you and your dependents will not have coverage under the Plan unless you enroll during the next open enrollment period, during a special enrollment period, or after a Change Event.

Open Enrollment Period

You may choose or change your participation in the Plan during your Health Ministry's annual open enrollment period. The elections you make during the open enrollment period will become effective on the first day of the next Plan Year.

It's important to make your enrollment decisions on time so be sure to make your elections by the date provided in your annual open enrollment materials.

You may not make any changes in your elections until the next open enrollment period except as provided in the *Special Enrollment Period* section below or unless you experience a qualifying Change Event. See *Change Events* later in this section for details.

Special Enrollment Period

As an Eligible Associate, you may change elections or enroll yourself or your Eligible Dependents outside of an open enrollment period (or after a Change Event) if you lose other coverage for certain reasons, have new Eligible Dependents, or become eligible for a Medicaid or Children's Health Insurance Program ("CHIP") premium assistance subsidy.

- **Loss of Other Coverage.** If you declined coverage under this Plan when first eligible because you were enrolled in other medical coverage, you may enroll yourself and Eligible Dependents if you have lost that other coverage for any one of these reasons:
 - You exhausted COBRA continuation coverage.
 - You lost eligibility for the other medical coverage.
 - An employer stopped making contributions to the other coverage.

You must make your elections within 30 days – or within 60 days if the other coverage was Medicare, Medicaid or CHIP – after the date that the other coverage ended.

- **New Eligible Dependent.** If you initially declined enrollment in the Plan for yourself or Eligible Dependents and you later have a new Eligible Dependent as a result of marriage, birth, adoption or placement for adoption, you may enroll yourself and your Eligible Dependents (including those who are not the new Eligible Dependent) in this Plan, provided that you request enrollment on or before the 30th day following the marriage, birth, adoption or placement for adoption.
- **Premium Assistance Subsidy.** If you or your Eligible Dependent becomes eligible for a Medicaid or CHIP premium assistance subsidy for qualified employer-sponsored health coverage, you may enroll yourself and your Eligible Dependent in the Plan, provided that you request enrollment – in writing – within 60 days after the date of eligibility.

Election changes that you make during a Special Enrollment Period will be effective as of your Change of Benefits Date.

Change Events

You cannot change your elections during the Plan Year unless you:

- Experience a Change Event, and
- Request a change – a change that is consistent with the Change Event – in writing within 30 days after the Change Event (or within 60 days after a Medicare, Medicaid or CHIP event).

For example, if one of your covered dependents no longer qualifies as an Eligible Dependent, you may cancel coverage for that covered dependent, but you may not cancel coverage for other covered Eligible Dependents. Or, if you have single coverage and marry, you may elect family coverage.

It is your responsibility to notify Ascension HR Central of a Change Event via fax or email within 30 days if you wish to change a benefit election. Even if your new baby is born in our Health Ministry facilities, it's still your responsibility to notify Ascension HR Central of the Change. The Hospital will not inform Ascension HR Central of your Change Event because that is your personal information.

An Eligible Associate may not change an election during the Plan Year with respect to any Legally Domiciled Beneficiary who does not satisfy the definition of dependent under Code Section 125(e)(1)(D) except under the following circumstances.

- An Eligible Associate may cancel coverage for the Legally Domiciled Beneficiary who does not satisfy the definition of dependent under Code Section 125(e)(1)(D) if he or she no longer qualifies as a Legally Domiciled Beneficiary.
- An Eligible Associate may change the coverage of an Eligible Dependent to Legally Domiciled Beneficiary coverage if the Eligible Dependent no longer satisfies the definition of Eligible Dependent because he or she is no longer a Child under age 26 but does satisfy the definition of Legally Domiciled Beneficiary.

To change an election mid-year because of these events, the Associate must submit (via fax or email) to Ascension HR Central and provide documentation that resulted in the change. Election changes will be effective on your Change of Benefits Date.

If you file the request later than 30 days after the Change Event (or later than 60 days after a Medicare, Medicaid or CHIP event), no changes will be made to your elections or Participant Contributions, but you may make the necessary change during the next open enrollment period for the following Plan Year.

Special Rule for Certain Leased Employees, Self-Employed Individuals or Independent Contractors

Leased employees, self-employed individuals and independent contractors who provide services to a Participating Employer are not eligible to participate in the Plan. If such an individual is determined to be a common law employee (and not a leased employee, self-employed individual or independent contractor), the individual will not be eligible to participate retroactively. Instead, such an individual's Entry Date will be the date on which the individual's reclassification as a common law employee was determined.

Participant Contributions

The enrollment instructions given to Eligible Associates will include details about the required Participant Contributions, based upon the type and level of coverage in which you are enrolled.

Family and Medical Leave Act

If you take a leave of absence under the Family and Medical Leave Act of 1993, you have the option of continuing or discontinuing your Plan coverage. Discuss your options with an Ascension HR Central representative before taking the leave.

When Coverage Ends

If you are an Eligible Associate, your coverage ends on the last day of the month (at 11:59 p.m.) in which you no longer meet the definition of Eligible Associate.

If you are an Eligible Dependent who loses eligibility for any reason including divorce or turning age 26, coverage ends at midnight on the date of the event (that is, at the beginning of the day of the date of the Change Event) on which you no longer meet the definition of Eligible Dependent.

You may be able to continue coverage, at your cost, for a limited time. See *Section 11* for details. Different rules may apply in the event of salary continuation or severance payments.

Termination for Cause

Your coverage can also be terminated for Cause for the reasons listed below. If coverage is terminated retroactively, you may be required to repay benefits that you received after the date that your coverage is terminated.

Your Coverage Can Be Terminated for “Cause” for these reasons:

- Your failure to provide to the Plan Administrator any information, document or form that the Plan Administrator determines is Reasonably Necessary for Plan administration or Plan Sponsor functions.
- Willful engagement in misconduct that is materially injurious to the Plan.
- Dishonesty in connection with provision of Plan benefits.
- Fraudulent or unethical conduct or an intentional misrepresentation of a material fact affecting Plan benefits.
- Failure to pay any amounts due to the Plan or Participating Employer.

Coverage can be terminated retroactively for:

- Failure to timely pay Participant Contributions.
- Fraudulent or intentional misrepresentation of a material fact.
- Any purpose not considered a “rescission” under the Patient Protection and Affordable Care Act.

If your coverage is terminated for failure to timely pay required Participant Contributions while you are not actively working due to leave of absence or disability, then subject to the terms and conditions of applicable policies of the Plan Administrator, you may be entitled to elect COBRA continuation coverage as described in *Section 11* as if your employment with your Participating Employer had ended for reasons other than gross misconduct.

Reinstatement

If you terminate employment and return within 30 days during the same Plan Year, your prior elections will be reinstated automatically. Otherwise, you will be treated as a new hire (see “Initial Enrollment Period”). However, if your Participating Employer has a different rule for reinstatement, that rule will apply instead of this one.

Transfers of Employment

If you transfer employment from one Participating Employer to another and you are eligible for the same SmartHealth benefits with the new employer, your benefit elections will not change.

If you are eligible for different SmartHealth benefits with the new Participating Employer, your elections prior to the transfer will remain in effect through the last day of the month coincident with or following the date of transfer. If you had satisfied the initial waiting period, you will not have to satisfy any waiting period with the subsequent Participating Employer and will be eligible to enroll in the new SmartHealth benefits effective as of the first day of the month following the date of your transfer.

Section 3: Your Medical Benefits

SmartHealth offers you comprehensive coverage for healthcare through a three-tier provider network structure. At enrollment, you enroll in a *Schedule of Benefits* offered by your Health Ministry, but you do not need to choose a doctor or Network until you need care. The Network you choose determines the level of benefits that you receive. You share in the cost of your coverage and the cost of your care for the medical expenses that are covered by the Plan.

Choosing Coverage

Choosing Coverage – Enrolling

The *Plan Outline* at the beginning of this SPD specifies the SmartHealth coverage/Plan options available to you. The *Schedules of Benefits* specify the level of benefits that will be paid for expenses covered under each option.

If your Health Ministry offers a choice of Schedules, this means that you have an opportunity to choose when you want to pay most of your share of costs, either:

- Before you need care (in payroll contributions), or
- When you obtain care (in out-of-pocket costs).

For details, including any exceptions, specified by your Health Ministry, see the *Plan Outline and Schedule(s) of Benefits* located at the beginning of this SPD or visit <https://mysmarthealth.org/>.

Your enrollment materials will include information about your share of the cost of coverage to be made through payroll deduction. Each *Schedule of Benefits* lists your share of cost when you obtain care or purchase supplies. The rest of this section explains more about how your coverage works.

Choosing Coverage – Obtaining Care

Each *Schedule of Benefits* offers access to the same three-tier structure of networks. You choose one of the following Networks when you obtain care:

- **Ascension Network:** Those facilities that are wholly or in part sponsored by a Health Ministry of Ascension Healthcare. Physicians in the Ascension Network shall have contracted with the Plan Administrator either individually on their own behalf or through the Health Ministry facility with whom they are affiliated. The Plan Administrator may designate or contract with other facilities and physicians to be part of the Ascension Network.
- **National Network:** Facilities or Physicians that are not Ascension Network facilities or physicians but are contracted with the National Network utilized by the Health Ministry.
- **Out-of-Network:** Those facilities or Physicians that do not participate in the Ascension Network or the National Health Network.

Generally, the Network you choose when you need care determines how much you pay. Although some services – such as preventive care services – are paid at the same level in both the Ascension and National Networks, you typically pay less when you visit an Ascension Network provider. Also, note that if you visit an Out-of-Network provider, you will pay substantially more, typically at least double the cost.

If the Health Ministry does not provide a certain service, or if you need to use another provider, you may choose a National Network provider and receive a National Network level of benefits.

In addition, because we recognize you may need to go Out-of-Network for certain care, an Out-of-Network level of coverage is provided if you choose Out-of-Network providers. However, these providers have not agreed to accept Network fees and may charge more than the Plan allows. Also, if no Ascension or National Network providers are available within 50 miles of your home address, care you receive from Out-of-Network providers will be paid at the National Network level, provided a benefit elevation is requested and approved. For more information on how to request a benefit elevation, please see the *Benefit Elevation Program* description in *Section 1* or go to <https://mysmarthealth.org/>, and after selecting your Health Ministry, click on **Information Center** and review the **Benefit Elevation** section.

How Expenses Are Covered

The Plan covers expenses that are identified as Covered Expenses under SmartHealth. For most Covered Expenses, once you satisfy the Deductible applicable to the specific type of provider you choose (that is, Ascension Network, National Network or Out-of-Network), you and SmartHealth share the expense as stated in your *Schedule of Benefits*. You pay for the full cost of the Covered Expense until you satisfy the applicable Deductible. Expenses that are identified as exclusions under SmartHealth are not considered Covered Expenses and you must pay the full cost of these exclusions. In general, the Plan covers expenses in the manner described below.

- You pay the flat dollar Copays, Deductibles and Cost-Share percentage listed on the *Schedule of Benefits* for care received from Ascension Network, National Network or Out-of-Network providers.
- After you satisfy the applicable Deductible for the year, if any, SmartHealth will pay a percentage (the Plan's Cost-Share) of the Covered Expenses.
- The amount of Covered Expenses you pay in a Plan Year (January 1 – December 31) will not exceed the Annual Out-of-Pocket Maximums listed on your *Schedule of Benefits*. Expenses that apply to the Annual Out-of-Pocket Maximum are stated in the *Schedule of Benefits*.
- Covered Expenses in one tier are applied to satisfy the Deductible and Annual Out-of-Pocket Maximum of the other tiers.
- Expenses that are covered under the Plan are listed as a Covered Expense; any service listed as an exclusion is not covered. See *Section 5* for additional information about Covered Expenses.
- Prior Authorization may be required. See *Section 6* for more information about Prior Authorization Requirements.
- If Out-of-Network providers charge fees greater than the Maximum Payable Charge, you may receive a "Balance Billing," as illustrated below. Balance Billing amounts do not count toward your Copays, Deductibles and Cost-Share or Annual Out-of-Pocket Maximum.

The "Cost-Share" percentage in SmartHealth works in the same way that "coinsurance" works under other insured plans. For instance, if the *Schedule of Benefits* shows a 20% Cost-Share in the National Network, that means the Plan pays 80% of Covered Expenses and you pay 20% for a total of 100%. If it shows a Cost-Share of 0% in the Ascension Network, the Plan pays 100% of Covered Expenses from Ascension Network providers.

As described in and subject to the specific details provided later in this SPD, the Plan pays for all of the Covered Expenses for certain preventive care that you receive from Ascension Network or National

Network providers. However, all benefits under the Plan are subject to certain maximums (as listed in the following table), applicable Prior Authorization requirements, general exclusions and other limitations. See *Section 5* and *Section 6* for more details about preventive care, Covered Expenses, exclusions, Prior Authorization and Retrospective Authorization requirements. See the *Plan Outline and Schedule(s) of Benefits* at the beginning of this SPD for exceptions specific to your Health Ministry.

Maximums

Covered Expenses paid for certain services or supplies will not exceed the maximums listed below:

Maximums Each Year (January 1-December 31)	
Annual Mammogram	1 test
Extended Care Facility	120 days
Residential Treatment Center	120 days
Residential behavioral health therapy programs	120 days
Routine Physical	1 exam
Annual Gynecological Exam	1 exam
Chiropractic Services	35 visits
Mastectomy Support Garments	Up to 4 every 12 months, provided that post-surgical camisoles are not subject to this limit.
Outpatient (including Home Care) Physical Therapy Outpatient (including Home Care) Occupational Therapy Outpatient (including Home Care) Speech Therapy	60 visits per year for all therapies combined. Additional visits subject to Prior Authorization.
Diabetes Education	1 program
Prescription Support Stockings	4 pairs
Therapeutic shoes for diabetes mellitus	<ul style="list-style-type: none"> • 1 pair of custom-molded shoes including inserts provided with the shoes and 2 additional pairs of inserts, or • 1 pair of depth shoes and 3 pairs of inserts not including the non-customized removable inserts provided with the shoes.
Home Health Care	100 visits
Pulmonary Rehabilitation	36 visits per condition
Eyeglasses including frames or contact lens following cataract surgery or contact lens for the diagnosis of keratoconus	\$250
Nutritional Counseling (other than for Nutritional Counseling for a diagnosed eating disorder)	The number of visits specified in the United States Preventive Services Task Force guidelines

Maximums Every 3 Years	
Foot orthotic replacement	2 pairs
Hearing Aid	\$2,000
Hearing Aid Dispensing fee (includes Hearing Aid check)	\$250
Purchase of a manual or non-hospital grade breast pump	1 pump
Scalp Hair Prosthesis	\$250
Cologuard Test	One every 3 years for patients 45 to 75 years old with normal colon cancer risk
Lifetime Maximums	
Power operated vehicle	Rental of one vehicle for up to 12 months or purchase of 1 vehicle per Participant during the period the Participant is covered by the Plan
Bariatric Surgery	One per Participant during the period the Participant is covered by the Plan

Visiting the Doctor

If your *Schedule of Benefits* lists a flat-dollar Copay for an office visit or E-visit, the doctor's office visit or E-visit charge is covered by the Copay. The Copay for the doctor's office visit or E-visit covers the basic evaluation. If additional services are provided by the doctor during an office visit or following an E-visit, the Cost-Share provision will apply after any Deductible has been satisfied. Some examples of additional services are lab tests, non-routine immunizations, x-rays, EKGs, and sometimes cardiac stress tests.

Visiting an Emergency Room or Urgent Care Facility

If you have an unexpected episode of Illness or Injury requiring treatment that cannot reasonably be postponed for a doctor's appointment, consider the severity of symptoms to determine if you should visit an Urgent Care Facility or an Emergency Room of a Hospital.

Medical Emergency. A "Medical Emergency" means a medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Emergency Room. If you receive care in an Emergency Room, you will receive benefits as listed in the *Schedule of Benefits*, which will be the same for all tiers. If you are admitted to an Ascension Network Hospital from the Emergency Room, you will receive Ascension Network benefits as listed in the *Schedule of Benefits*. If you are admitted to a National Network or Out-of-Network Hospital from the Emergency Room, you will receive National Network benefits as listed in the *Schedule of Benefits*. If you are transferred from an Ascension Network Emergency Room and admitted to a National Network or Out-of-Network Hospital, you will also receive Ascension Network benefits as listed in the *Schedule of Benefits*. The Emergency Room visit Copay will not be charged if you are admitted.

If you incur Covered Expenses for Outpatient services as the result of an Emergency Room visit or admission (including without limitation follow-up care incurred as the result of an Emergency Room visit or admission), these Covered Expenses for services in an Out-of-Network Hospital will be paid as listed in the National Network column of the *Schedule of Benefits*, subject to certain conditions. In this case, you will pay the Copays and/or Cost-Shares listed in the National Network column of the *Schedule of Benefits*.

Urgent Care. Depending upon the severity of the unexpected symptoms, you may wish to choose an Urgent Care Facility to lower your costs. By doing this, you will avoid the Emergency Room visit Copay, and either:

- Receive the higher Tier 1 Urgent Care Facility benefits, or
- Receive the Tier 2 or Tier 3 Cost-Share benefit after satisfying the Tier 2 Deductible.

Receive the Higher Urgent Care Benefit Coverage When You Travel

If you need medical care while traveling, you should go online to <https://mysmarthealth.org/> to determine the availability of Ascension Network or National Network providers in the area you are traveling to. If none are available, the Out-of-Network benefits will apply unless your episode is a Medical Emergency, or the treatment is provided by a facility or provider that has contracted with the Claims Administrator to provide such treatment or services.

If you travel outside of the United States, its protectorates, Canada or Mexico, any treatment or services will not be covered unless the treatment is for a Medical Emergency.

Benefits are subject to annual maximums (listed on the previous pages), any Prior Authorization requirements, general exclusions and other limitations. See *Section 5* and *Section 6* for lists of specific requirements. See the *Plan Outline and the Schedule(s) of Benefits* at the front of the SPD for exceptions specified by your Health Ministry.

Section 4: Your Prescription Drug Benefits

Prescription Drug Services

Prescription Drug Benefits may be obtained via the following programs:

- Ascension Rx Pharmacy. Participants may purchase Covered Drugs at an in-house Ascension Rx Pharmacy subject to any Cost-Sharing amount specified in the applicable *Schedule of Benefits*. To determine if an Ascension Rx Pharmacy is located near you, go to <https://ascensionrx.com/> and click on “Find an Ascension Rx retail pharmacy.”
- Retail Pharmacy. Participants may:
 - Purchase Covered Drugs at any *participating* retail pharmacy subject to any Cost-Sharing amount specified in the *Schedule of Benefits*, or
 - Purchase Covered Drugs at a *nonparticipating* retail pharmacy, in which case the Participant will be required to pay the full cost of the Covered Drug but may file a claim for reimbursement with the Claims Administrator on forms provided by the Claims Administrator, subject to any Cost-Sharing amount specified in the *Schedule of Benefits*.

See your *Schedule of Benefits* at the beginning of this SPD for applicable Cost-Share, Deductible, Copay and Annual Out-of-Pocket Maximum amounts.

Note: Participants will receive an identification card from Cigna that should be used when filling prescriptions at participating retail pharmacies.

- Ascension Rx Home Delivery. In order for a qualifying Maintenance Medication to be a Covered Drug for a 90-day supply under the Plan, Participants must purchase Maintenance Medications through Ascension Rx Home Delivery, subject to any Cost-Sharing amount specified in the *Schedule of Benefits*.

Important Note: Participants can fill or refill 30-day supplies of qualifying Maintenance Medications at any participating pharmacy that is part of Cigna’s network, without being responsible for the full cost of the Maintenance Medication. In addition, such cost will count towards any Deductible, Copay, Annual Out-of-Pocket Maximum or similar accumulator. **However, a 90-day supply of a qualifying Maintenance Medication is only a Covered Drug under the Plan if purchased through Ascension Rx Home Delivery or an in-house Ascension Rx Pharmacy. If not, the Participant will be required to pay the full cost of the Maintenance Medication, and such cost will not count towards any Deductible, Copay, Annual Out-of-Pocket Maximum or similar accumulator.**

- Ascension Rx Specialty Pharmacy. In order for a Specialty Medication to be a Covered Drug under the Plan, Participants must purchase Specialty Medications from the Ascension Rx Specialty Pharmacy, subject to any Cost-Sharing specified in the applicable *Schedule of Benefits*. If a Participant purchases Specialty Medications elsewhere then: (i) the Specialty Medication is not a Covered Drug, (ii) the Participant will be required to pay the full cost of the Specialty Medication, and (iii) such cost will not count towards any Deductible, Copay, Annual Out-of-Pocket Maximum or similar accumulator.

Limitation on Payments

With respect to prescriptions filled through any of the programs described above, the amount which will be paid by the Plan will be net of the Deductible, Copay and Cost-Share amounts stated in your *Schedule of Benefits*.

Application of Cost-Sharing Amounts

Except with respect to Participants who Participate in a high-deductible health plan and/or except as provided in an Addendum, any amount that the Participant is required to pay when purchasing prescription medication will not be applied to the deductible.

Covered and Excluded Prescription Drugs

The Claims Administrator maintains a list of covered and excluded prescription drugs, supplies and other items, which are approved by the Plan Sponsor. The list of covered and excluded prescription drugs, supplies and other items is subject to change from time to time as the Plan Administrator shall determine and shall be made available to Participants. In no event will the Plan make reimbursement or payment for any prescription drugs, supplies or other items listed as excluded on such list. Prior Authorization requirements for retail medications will be administered by the Claims Administrator.

Payment of Prescription Drug Benefits

The Plan Administrator in its sole discretion shall direct the Claims Administrator to pay to a Participant, Dependent or Legally Domiciled Beneficiary any amount to which he or she is entitled under the Plan from time to time. In lieu of making payment to the Participant, Dependent or Legally Domiciled Beneficiary, the Claims Administrator shall be authorized to make payment directly to the applicable service provider.

Manufacturer Patient Assistance Programs (PAPs)

Amounts applied to the cost of prescription drugs under a PAP do not count towards any Deductible, Copay, Annual Out-of-Pocket Maximum or similar accumulator.

Section 5: Covered Expenses and Exclusions

All of the services and supplies covered by the Plan – Covered Expenses – are listed in this section. For most Covered Expenses, once you satisfy the Deductible applicable to the specific type of provider you choose (that is, Ascension Network, National Network or Out-of-Network), you and SmartHealth share the expense as stated in your *Schedule of Benefits*. You pay the full cost of the Covered Expense until you satisfy the applicable Deductible.

Any services or supplies listed as exclusions in this section are not covered under the Plan, and therefore you are responsible for any costs related to such exclusions. Any such costs that you pay do not count toward your Copays, Deductibles, and Cost-Share or Annual Out-of-Pocket Maximum.

Subject to the limitations described below, the Plan pays for all preventive care services received from Ascension Network and National Network providers. Such preventive care services are not subject to Cost-Sharing (that is, Deductibles, Cost-Shares and Copays).

Covered Expenses and Exclusions

All of the services and supplies covered by the Plan – Covered Expenses – are listed below. In addition to being listed below and meeting other applicable requirements of the Plan, in order for a service to constitute a Covered Expense, the service must meet requirements of applicable policies of the Plan’s utilization vendor. Any service listed below as an exclusion is not covered. Note: Prior Authorization requirements may apply for certain services (see *Section 6* for additional details).

Alternative Treatment Plans
<p>In addition to the benefits described in the <i>Schedule of Benefits</i>, the Plan Administrator has the discretion to offer benefits for services furnished pursuant to a Plan-approved alternative treatment plan.</p> <p>However, such benefits will be offered only if the Plan Administrator determines that the cost of the alternative treatment plan will be lower than the cost of treatment under the applicable <i>Schedule of Benefits</i>.</p> <p>The Plan Administrator is not obligated to approve alternative-treatment benefits for a Participant merely because the Plan Administrator approved the same or similar treatment for another Participant.</p> <p>In addition, if the Plan Administrator decides to approve alternative treatment for a Participant in one instance, the Plan Administrator is not obligated to approve the same or similar treatments for that same Participant in another instance.</p>

Ambulance, Transfer and Inter-Facility Transport	
<p>The Plan covers:</p> <ul style="list-style-type: none"> Professional ground or air ambulance required because of an accidental bodily Injury or a Medical Emergency to the nearest point of medical treatment (including a transfer if you are unstable and require equipment, services or personnel not available at the facility) or, if requested by a Participant, transport service to the nearest equipped Ascension Network facility when the ground or air ambulance is required because of an accidental bodily Injury or a Medical Emergency even if the Ascension Network facility is not the closest facility, provided that the Participant's outcome will not be jeopardized by a farther transport. Medically Necessary, non-emergency transfer via an appropriately equipped vehicle from one facility to another or from a facility to home. Inter-facility patient transport by air transport for Participants if there is a life-threatening situation or it is otherwise deemed to be Medically Necessary. 	<p>For a patient who is in a Hospital or other health care facility under the care or supervision of a licensed health care provider, a Prior Authorization is required before transport of the patient via air transport or any form of flight to another Hospital or facility.</p> <p>Failure to obtain a Prior Authorization number from SmartHealth may, solely in the Plan Administrator's discretion, result in a denial of benefits for charges arising from or related to inter-facility patient transport via air/flight.</p> <p>The Plan Administrator retains the discretionary authority to limit benefit availability to alternate providers of flight-based inter-facility patient transport if and when a provider fails to comply with the terms of the Plan or proposed charges exceed the maximum allowable in accordance with the terms of the Plan.</p> <p>If a Participant incurs Covered Expenses for ground ambulance services with an Out-of-Network provider that would be covered expenses but for the fact that the provider is Out-of-Network, the Plan Administrator may, in its discretion, negotiate with such Out-of-Network provider to pay such provider an amount in addition to the Maximum Payable Charge for such service, in exchange for the provider's agreement to reduce or forego Balance Billing for such service. Unlike ground ambulance services, air ambulance services are covered under the No Surprises Act and the Plan Administrator will follow the requirements of such act.</p>
Blood	
<p>The Plan covers expenses for:</p> <ul style="list-style-type: none"> Blood and blood plasma, and their administration. Autologous blood transfer and blood storage. 	
Cardiac Rehabilitation	
<p>The Plan covers expenses for:</p> <ul style="list-style-type: none"> Cardiac Rehabilitation–Phase I provided in Inpatient setting. Cardiac Rehabilitation–Phase II for patients who: <ul style="list-style-type: none"> Have a documented diagnosis of acute myocardial infarction within the preceding 12 months. Have had coronary bypass surgery, balloon angioplasty, a cardiac transplant, or a heart valve replacement. Have congestive heart failure or stable angina pectoris. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> Cardiac Rehabilitation–Phase III.

Cosmetic Surgery	
<p>The Plan covers expenses for:</p> <ul style="list-style-type: none"> • Cosmetic Surgery when performed to correct deformities under the following circumstances: <ul style="list-style-type: none"> – As a result of an Injury or Illness. – As a result of a congenital defect which interferes with a function of the body. – Scar revision necessary to correct a deformity caused by an accidental Injury or Surgical Procedure. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Breast implants for solely cosmetic reasons, except when specifically provided under covered services.
Dental Services	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Treatment of Injuries to sound natural teeth under the following circumstances: <ul style="list-style-type: none"> – The treatment must be necessary due to accidental damage to the tooth; and – The damage was severe enough to be evaluated by a Physician or Dentist within 72 hours of the accident; and – The services are provided by a DDS or DMD or an oral and maxillofacial surgeon; and – The dental services begin within 3 months of the accidental Injury and completed within 12 months of the accident, except in the case of a pediatric patient with respect to whom a delay in treatment is medically warranted. <p>The Plan also covers these dental procedures:</p> <ul style="list-style-type: none"> • Excision or removal of lesions and tumors, including non-odontogenic cysts, tumors, or lesions of the jaws, cheeks, lips, tongue, roof and floor of mouth. • Excision of benign bony growths of the jaw and hard palate. • Incision of sensory sinuses, salivary glands, or ducts. • Surgery to correct Injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth. <p>The Plan also covers Hospital Charges for:</p> <ul style="list-style-type: none"> • Multiple tooth extractions and/or removal of un-erupted teeth when required due to a related medical condition. • When a concurrent medical condition exists that prevents the dental procedure(s) from being safely performed in an office setting. • Treatment of Injuries to sound natural teeth. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Vestibuloplasty. • Expenses in connection with the prevention or correction of malocclusion of the teeth by wire braces or any other treatment methods. • Treatment of periodontal or periapical disease. • Any condition involving teeth or surrounding tissue or structure. • Any dental prostheses or dental implants. • Any dental services or dental x-rays unless the service is eligible under Covered Medical Expenses. • Excision/destruction of dentoalveolar structures, with or without repair.

Dialysis	
<p>The Plan covers dialysis for the first 30 months of treatment. After the 30th month of treatment, the Participant is eligible for Medicare coverage due to End Stage Renal Disease. Upon eligibility for Medicare coverage, the Plan becomes the Secondary payer for the Participant's dialysis treatment. <u>Note</u>: The Plan will be the Secondary payer regardless of whether the Participant actually signs up for Medicare.</p>	
Durable Medical Equipment (DME)	
<p>The Plan covers Durable Medical Equipment (for example, standard wheelchair, Hospital bed, oxygen and equipment, etc.) as follows:</p> <ul style="list-style-type: none"> • Rental, or • Purchase – if the Plan Administrator determines that purchasing is either less expensive than 12 months rental through an Ascension Network provider (or 10 months through a National Network or Out-of-Network provider) or is the most appropriate avenue of obtaining equipment. Benefits include phototherapy blankets, apnea monitors (rental item only) pulse oximeters and breast pumps. Lifetime maximum of one power-operated vehicle per Participant during the period the Participant is covered by the Plan. • Benefits include reimbursement for support services (set-up, delivery, training, on-going assistance, etc.). 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Air conditioners, purifiers, humidifiers, heating pads, cold pads, hot water bottles. • Elastic bandages, blood pressure kits, first aid kits. • Percutaneous Electrical Nerve Stimulation for peripheral nerve stimulation. • Electronically controlled thermal (hot or cold)/compression therapy units with mechanical pumps. • Pulsed electrical stimulation units for osteoarthritis; for example, the Bionicare® System BIO-1000TM. • Convenience items.
Emergency Care	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Emergency Room visit. • Urgent Care Facility visit. 	
Extended Care Facility	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Room and Board. • Other services and supplies ordered by a Physician and furnished by the Extended Care Facility for Inpatient medical care – up to a 120-day annual maximum. • Nursing care or other professional services only if the patient is under the continuous care of the patient's Physician or 24-hour nursing care is essential. • TBI (Traumatic Brain Injury) rehabilitation programs that have physician oversight and include all or some of the following modalities: physical therapy, occupational therapy, speech therapy, nursing, social work and psychologists and neuropsychologists in the treatment and recovery of traumatic brain injury; provided, however, that the Participant must be able to actively participate in the treatment plan and continue to make progress toward established goals. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Custodial Care. • Cost of schooling provided by the facility.

Hearing	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Diagnostic hearing exams. • Hearing aids – up to \$2,000 per Participant every 3 years when received from a designated provider based on the <i>Schedule of Benefits</i>. • Hearing aid dispensing fee, including hearing aid check (up to \$250 every 3 years). • Cochlear implants. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Hearing aid batteries.
Home Health Care	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Part-time or intermittent nursing care by or under the supervision of a registered nurse (up to 100 visits per year) <u>Note:</u> Each visit by a member of a Home Health Agency care team, consisting of not more than 4 hours of service, will be considered one Home Health Agency care visit. • Physical therapy, occupational therapy, speech therapy (60 visits per year for all therapies combined; Prior Authorization is required for visits in excess of 60). • Medical supplies. • Masters-prepared social workers (MSW). 	
Hospice	
<p>The Plan covers the following services ordered by a Physician:</p> <ul style="list-style-type: none"> • Hospice Care Program expenses, including Custodial Care, if a Physician's statement verifies that your life expectancy is no longer than 6 months. 	
Human Organ Transplants	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Human organ (organ, bone marrow, other) expenses, but only those that are Medically Necessary. • If the Participant is the recipient, charges for obtaining donor organs are covered. Donor charges include those for evaluating the organ, removing the organ from the donor, and transportation of the organ from within the United States and Canada to the place where the transplant is to take place. When the donor has medical coverage, the donor's plan will pay Primary. The benefits under this Plan will be reduced by those payable under the donor's plan. • If the organ donor is a Participant and the recipient is not, then the Plan will cover donor organ charges for evaluating the organ and removing the organ from the donor. • The Plan also covers stem cell transplants (bone marrow, peripheral blood and umbilical cord blood stem cells) for any condition deemed to be Medically Necessary. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Organ/stem cell transportation charges in relation to human organ or stem cell transplant when the donor is a Participant, and the recipient is not.

Human Organ Transplants (continued)

- Also covered are donor charges when the stem cell recipient is a Participant. Donor charges include those for activation of an unrelated donor search through the National Marrow Donor Program (NMDP), confirmatory typing of donor samples (including infectious disease tests), genetic evaluation, stem cell collection and transportation of the stem cell to the place where the transplant is to take place.
- If the stem cell donor is a Participant and the recipient is not, then the Plan will cover donor charges for genetic evaluation and collection of the stem cells. When the donor has medical coverage, the donor's plan will pay Primary. The benefits under this Plan will be reduced by those payable under the donor's plan.

Inpatient Services

The Plan covers:

- Room and Board and special care unit accommodations furnished by the Hospital, including Birthing Center accommodations.
- Hospital services and supplies furnished by a qualified Hospital to you while Hospital Confined, such as operating room, x-rays, laboratory tests, drugs, medicines, general nursing care, anesthesia, radiation therapy, and blood or blood plasma.
- Hospital Observation Stay services.
- Surgical Procedures including preoperative and postoperative care.
- Services of a technical surgical assistant when deemed to be required for a Surgical Procedure or obstetrical procedure.
- Anesthetics and oxygen and their administration by a Physician or Certified Registered Nurse Anesthetist (CRNA).
- Physician charges for visits by a Physician during the period of Hospital Confinement.
- Chemotherapy.
- X-ray and radium treatments and treatments with other radioactive substances.
- Emergency Room admission.

Note: Benefits for ancillary services during a Hospital Confinement are paid based on the Network status of the specific provider. For example, if an anesthetist at an Ascension Network hospital is a National Network provider, then anesthesia is covered at the Ascension Network level.

Exclusions – Expenses will NOT be paid for:

- Hospital Confinement charges incurred in a facility other than an approved Hospital or Birthing Center.
- Hospital Confinements primarily for physical check-ups and rest cures.
- Charges for convenience items, including TV, telephone, guest beds, etc.
- Expenses for anesthesia for procedures that are not covered by the Plan.
- Supervision of more than four CRNAs.

Mastectomy Services	
<p>The Plan covers:</p> <ul style="list-style-type: none"> Charges for or in connection with a mastectomy consistent with the Women's Health & Cancer Rights Act of 1998 including: <ul style="list-style-type: none"> Reconstruction of the breast on which the mastectomy was performed. Surgical Procedures and reconstruction of the other breast, to produce a symmetrical appearance. Prostheses and physical complications of all stages of mastectomy, including lymphedemas and lymphedema sleeves. Mastectomy support garments up to 4 every 12 months, provided that surgical camisoles are not subject to this limit. This coverage must be provided in a manner determined in consultation with the attending Physician and patient. This coverage will be subject to Deductible, Cost-Share or Copay provisions as stated in the <i>Schedule of Benefits</i>. 	<p><u>Exclusions</u> – Expenses will NOT be paid for custom-made prostheses.</p>
Maternity and Newborn Care	
<p>The Plan covers:</p> <ul style="list-style-type: none"> Hospital admission of 48 hours following a vaginal delivery, or 96 hours following a Cesarean delivery, for an eligible admission. Note: there will be no per admission Copay taken on initial newborn confinement. Care for routine nursery charges for a newborn child while the mother is confined in the Hospital. <u>Note</u>: The requirement that the confinement be as a result of Illness or Injury will not apply to Hospital Confinement charges of a newborn while the mother is confined. Routine Physician visits during the initial Hospital Confinement. Prenatal and postnatal care, including required visits to the doctor's office and Medically Necessary laboratory tests and ultrasounds related to a covered Pregnancy. Circumcisions. Lactation support, supplies and counseling as provided for under applicable policies of the Plan Administrator or the Plan's utilization vendor. Home uterine monitoring, including devices. Birthing and delivery services by a Midwife in an approved Hospital or Birthing Center. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> The initial examination of a newborn by the delivery Physician. Home birthing and delivery services. Services provided by a Midwife in a facility other than an approved Hospital or Birthing Center.

Mental Health and Psychiatric Treatment

The Plan covers mental health and Psychiatric Treatment including Inpatient, Partial Day Treatment, Intensive Outpatient, and Individual or Group Therapy, as follows:

- Acute Hospital and Accredited Care Facility admissions.
- Partial Hospital Confinement provided by Hospitals or Accredited Care Facilities. All eligible charges in conjunction with this care will be considered as charges of a Hospital Confinement.
- Electroshock therapy when administered by a Physician.
- Anesthesia for electroshock therapy when administered by a Physician other than the Physician administering the electroshock therapy or by a Certified Registered Nurse Anesthetist (CRNA).
- Detoxification, including voluntary sub-acute detoxification provided by an acute Hospital or Accredited Care Facility.
- Intensive Outpatient Therapy provided by a Hospital or Accredited Care Facility.
- Intensive Outpatient Therapy with domicile provided by an approved facility.
- Individual, Family or Group counseling or therapy provided by a licensed psychiatrist (MD or DO), licensed psychologist (LP – Doctorate Psychologist), limited licensed psychologist (LLP – Masters Psychologist), licensed professional counselor (LPC – Masters Counselor), licensed master social worker (LMSW – Masters Social Worker), licensed nurse with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license).
- Psychiatric evaluation, treatment and medication reviews when provided by a psychiatrist.
- Psychological, neuropsychological or neurobehavioral status testing provided by a psychiatrist or person qualified in the particular area of testing.
- Transcranial Magnetic Stimulation treatment to treat major depressive disorder.
- Nutritional counseling for eating disorder diagnosis.

Exclusions – Expenses will NOT be paid for:

- Except with respect to services provided in connection with specialized inpatient programs for traumatic brain injury that include daily physician visits, physical therapy, occupational therapy, speech therapy and 24-hour nursing coverage, professional services for Psychiatric Treatment and Substance Use Disorder care provided by anyone other than a licensed psychiatrist (MD or DO), licensed psychologist (LP– Doctorate Psychologist), limited licensed psychologist (LLP – Masters Psychologist), licensed professional counselor (LPC– Masters Counselor), licensed master social worker (LMSW– Masters Social Worker), or licensed nurse with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license).
- Cost of schooling provided by the facility.

Outpatient Services/Diagnostic/Testing

The Plan covers:

- Diagnostic radiology and procedures, laboratory testing, pathological examinations and sleep studies when ordered by a Physician for the diagnosis of an Illness or Injury.
- Anesthetics and oxygen and their administration by a Physician or Certified Registered Nurse Anesthetist (CRNA).
- Hospital services and supplies furnished by a qualified Hospital to you as Outpatient, such as operating room, x-rays, laboratory tests, drugs, medicines, general nursing care, radiation therapy, and blood or blood plasma.
- Surgical Procedures including preoperative and postoperative care.
- Services of a technical surgical assistant when required for a Surgical Procedure or obstetrical procedure.
- Ambulatory Care Center charges in connection with a covered Surgical Procedure.
- Stereotactic radiosurgery.
- Chemotherapy.
- Testing to diagnose infertility and treatment only when Medically Necessary under applicable policies of the Plan's utilization vendor.
- Genetic testing approved by the Plan Administrator to determine the viability of a Pregnancy or to diagnose a potential birth defect prior to Pregnancy.
- Cell-free fetal DNA testing for fetal aneuploidy; Prior Authorization required for BRCA1 and BRCA2 genetic testing and pre-test education and include large genomic rearrangement testing (BART).
- Oncotype DX Gene Expression Profiling and MammaPrint testing for breast cancer (subject to other applicable requirements of the Plan, all such profiling and testing will be approved at the Ascension Network level).
- Physiotherapy treatment by a licensed physiotherapist (60 visits per year for Physical Therapy, Occupational Therapy and Speech Therapy combined; Prior Authorization required for visits in excess of 60).
- Occupational therapy by a licensed occupational therapist (60 visits per year for Physical Therapy, Occupational Therapy and Speech Therapy combined; Prior Authorization required for visits in excess of 60).
- Sleep studies provided in a facility or private residence.

Exclusions – Expenses will NOT be paid for:

- Expenses for anesthesia for procedures that are not covered by the Plan.
- Supervision of more than four CRNAs.
- Paternity testing.
- Magnetic resonance guided focused ultrasound for the treatment of leiomyomata when performed by a National Network or Out-of-Network provider if an Ascension Network provider is available.
- Expenses will not be paid for any services or supplies related to assisted reproduction or artificial conception as described in the policy.
- Sleep studies provided in a facility that have not been preauthorized.

Outpatient Services/Diagnostic/Testing (continued)	
<ul style="list-style-type: none"> • Treatment (60 visits per year for Physical Therapy, Occupational Therapy and Speech Therapy combined; Prior Authorization required for visits in excess of 60) by a licensed, qualified speech therapist for the purpose of restoring loss of the ability to swallow, speech loss or correcting an impairment due to: <ul style="list-style-type: none"> – A congenital defect for which corrective surgery has been performed. – An Injury or Illness which caused the loss of the ability to speak. – An Injury or Illness which caused the loss of the ability to speak. – Never having the ability to speak or swallow. – A stuttering severity of moderate or greater as evidenced by standard testing. – A Developmental Delay. • Hemodialysis. • Pulmonary Rehabilitation (36 visits per condition). • Prescribed Medical supplies and treatment, home and office visits by a Physician, E-visits, and other medical care as deemed necessary for the treatment of an Illness or Injury. • Chiropractic services – annual maximum of 35 visits. • Magnetic resonance guided focused ultrasound for the treatment of leiomyomata. • Charges for temporomandibular joint (TMJ) appliances. 	
Prescribed Medical Supplies	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Artificial eyes and larynx. • Casts, splints, trusses. • Electronic heart pacemaker. • Prescription support stockings (up to 4 pairs annually). • Therapeutic shoes, inserts, and modifications for primary or secondary diabetes mellitus even if only one foot suffers from diabetic foot disease (an annual limit of 1 pair of custom-molded shoes including inserts provided with the shoes and 2 additional pairs of inserts or 1 pair of depth shoes and 3 pairs of inserts not including the non-customized removable inserts provided with the shoes). • Wound care/dressing supplies. • Other prescribed medical supplies. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Standard shoes. • Deluxe features such as color, type of leather, or style of off-the-shelf depth inlay shoe or custom-molded shoe. • Fitting of the shoes, inserts or modifications on a separate basis. • Inserts used in non-covered shoes.

Prescription Drug and Medical Specialty Drug Benefits

The Plan covers prescription drug benefits as specified in the *Schedule of Benefits*.

Exclusions – Expenses will NOT be paid for prescriptions for:

- Over-the-counter (OTC) medications used to treat heartburn, stomach ulcer or stomach acid conditions, such as Proton Pump Inhibitors (for example, Prilosec, Prevacid, Protonix, Dexilant, Aciphex, etc.) and H2 Blockers (for example, Pepcid, Zantac and Tagamet).
- Oral 2nd generation allergy, eye allergy and nasal allergy medications (for example, Claritin, Clarinex, Zyrtec, Allegra, Pataday, Flonase, Nasonex, etc.).

Note: The Participant will be required to pay the full cost of any of the OTC medications or medication classes listed above, and such costs will not count towards any Deductible, Copay, Annual Out-of-Pocket Maximum or similar accumulator.

Exclusions – In addition to any other exclusions provided above, under the *Schedule of Benefits*, this SPD or any other policy or document, expenses will NOT be paid for:

- Newly FDA-Approved medical benefit drug/medical specialty drug claims incurred on or after June 1, 2022 with unclassified codes, or
- Medical benefit drug/medical specialty drug claims for classified, coded medications that are new to the U.S. market, until the Ascension Therapeutic Affinity Group: TAG (National P&T) has completed a formal evaluation of the new classified, coded medication.

Note: Following the FDA's approval of a new medication in the U.S., there will be a waiting period of at least six months before any new medication will be considered for evaluation by TAG.

Preventive Care Services

The Plan covers:

- The following services to the extent such services are required to be provided without Cost-Sharing (such as Deductibles, Cost-Shares and Copays) under the PPACA in accordance with the Preventive and Diagnostic Care Codes:
 - Items or services that have a rating of ‘A’ or ‘B’ in the current recommendations of the United States Preventive Services Task Force,
 - Immunizations recommended by the Advisory Committee on Immunization Practices that have been adopted by the Director of the Centers for Disease Control and Prevention,
 - Evidence-informed preventive care and screenings for infants, children and adolescents as provided for in the comprehensive guidelines by the Health Resources and Services Administration (HRSA), and
 - Evidence-informed women’s preventive care and screenings per HRSA guidelines.
- The following services, which are subject to applicable Cost-Sharing requirements (such as Deductibles, Cost-Shares and/or Copays) to the extent such services (i) are not covered under the preceding paragraph and (ii) exceed the services required to be paid without Cost-Sharing under the PPACA:
 - Annual routine physical.
 - Annual gynecological exam.
 - Well baby/child examinations including related testing.
 - Annual mammogram.
 - Annual pap smears.
 - Routine immunizations.
 - Lactation support, supplies and counseling as provided for under applicable policies of the Plan Administrator or the Plan’s utilization vendor.
 - Prostate specific antigen (PSA) test.
 - Colonoscopy (per Plan guidelines).
 - Flexible sigmoidoscopy (per Plan guidelines).
 - Counseling and instruction in natural family planning and related services, including NaPro technologies.

Exclusions – Expenses will NOT be paid for:

- Vaccines for travel.
- Any service listed as an exclusion regardless of whether the service is listed as being covered in the column to the left.

For additional information about preventive care services go online to:

- The **Information Center** section of <https://mysmarthealth.org/>.
- **ACA Health Insurance Exchange:** <https://www.healthcare.gov/coverage/preventive-care-benefits/>.
- [SmartHealth Preventive Care Services 2023](#).
- [Overview of SmartHealth Preventive Services](#).

Important Note: The Preventive Care Services list in this section provide just an abbreviated summary. Go online to view [SmartHealth Preventive Care Services 2023](#), which is the governing document that determines which preventive care services will be covered without Cost Sharing and what limitations will apply to the coverage of such services.

Mutually Exclusive Services	
<p>Each Plan Year, only 2 of the following 3 services will be considered Covered Expenses under the Plan:</p> <ul style="list-style-type: none"> • 1 annual well-woman visit with a primary care provider. • 1 annual gynecological examination. • 1 natural family planning examination. 	<p>If the Participant receives one or two of the services in a Plan Year, the services will be covered as preventive care services. If a Participant receives all 3 services in a Plan Year, only the first 2 services the Participant receives will be covered as preventive care services. The third service will be covered to the extent provided in other Plan provisions. <u>Note</u>: The Plan will not cover 2 routine physical examinations per year; the Plan will only cover 1 routine physical per year.</p>
Prosthetics and Orthotics (P&O)	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Prosthetics, orthotics, braces (including attached corrective shoes). • Foot orthotics (custom-fabricated removable inserts or arch supports) for no more than 2 pairs every 3 years. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Orthopedic shoes (except those which are an integral part of a corrective brace). • Corrective shoes. • Off-the-shelf or over-the counter foot orthotics/products.

Substance Use Disorder	
<p>The Plan covers Substance Use Disorder including Inpatient, Partial Day Treatment, Intensive Outpatient, and Individual or Group Therapy, as follows:</p> <ul style="list-style-type: none"> • Acute Hospital and Accredited Care Facility admissions. • Partial Hospital Confinement provided by Hospitals or Accredited Care Facilities. All eligible charges in conjunction with this care will be considered as charges of a Hospital Confinement. • Detoxification, including voluntary sub-acute detoxification, provided by an acute Hospital or Accredited Care Facility. • Intensive Outpatient Therapy provided by a Hospital or Accredited Care Facility. • Intensive Outpatient Therapy with domicile provided by an approved facility. • Individual, family or group counseling or therapy provided by a licensed psychiatrist (MD or DO), licensed psychologist (LP – Doctorate Psychologist), limited licensed psychologist (LLP – Masters Psychologist), licensed professional counselor (LPC – Masters Counselor), licensed master social worker (LMSW – Masters Social Worker), licensed nurse with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license). • Psychiatric evaluation, treatment and medication reviews when provided by a psychiatrist. • Psychological, neuropsychological or neurobehavioral status testing provided by a psychiatrist or person qualified in the particular area of testing. • Acute Inpatient care for Substance Use Disorder. • Residential treatment care in a Residential Treatment Center only when the Participant’s condition (i) makes treatment beyond Outpatient services Medically Necessary and (ii) can be safely, efficiently, and effectively treated in a less intensive level of care than an Inpatient Hospital setting. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Professional services for Psychiatric Treatment and Substance Use Disorder care provided by anyone other than a licensed psychiatrist (MD or DO), licensed psychologist (LP– Doctorate Psychologist), limited licensed psychologist (LLP– Masters Psychologist), licensed professional counselor (LPC– Masters Counselor), licensed master social worker (LMSW– Masters Social Worker), or licensed nurse with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license).
Travel	
<p>Reimbursements for travel expenses are allowed pursuant to the applicable policies of the Plan Administrator or the Plan’s utilization vendor. The policy allows for specified travel expenses when a Participant seeks specified services at an Ascension Network facility that are not available at the Participant’s own Health Ministry. This benefit is available only for Inpatient services at Ascension Network facilities.</p>	<p>Except for travel expenses that are reimbursable under the applicable policies of the Plan Administrator or the Plan’s utilization vendor, the Plan excludes coverage for travel, including travel recommended by a Physician and travel to and from any location at which the Participant obtains services covered under the Plan.</p>

Vision	
<p>Eyeglasses, including frames, or contact lenses following cataract surgery or contact lenses for the diagnosis of keratoconus up to a \$250 maximum.</p>	<p>Except as provided in this section, expenses will NOT be covered for:</p> <ul style="list-style-type: none"> • Eyeglasses. • Contact lenses. • Examination for prescribing and/or fitting of eyeglasses and contact lenses. • Examinations for determining the refraction state of the eye.
Weight-Loss Services	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Physician-supervised weight loss services. • Nutritional counseling (maximum of 3 visits per year). 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Exercise services offered in a Physician's office. • Diet supplements and/or meal replacements. • Weight loss drugs. • Other weight loss programs; for example, Weight Watchers, Jenny Craig, etc.
Weight-Loss Surgery	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Bariatric Surgery (Plan maximum of one surgery per Participant). • Prior Authorization required. • Covered only when Medical Necessity criteria is met. • Revision of a previous bariatric surgical procedure or conversion to another Medically Necessary procedure for an adult due to inadequate weight loss is considered Medically Necessary when: <ul style="list-style-type: none"> – Due to a technical failure of the original bariatric surgical procedure (e.g., pouch dilatation, unsuccessful band adjustments), the individual has failed to achieve adequate weight loss, which is defined as failure to lose at least 50% of excess body weight or failure to achieve body weight to within 30% of ideal body weight at least two years following the original surgery. – In the absence of a technical failure or major complication, individuals with weight loss failure \geq two years following a primary bariatric surgery procedure must meet the initial Medical Necessity criteria for surgery. 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Certain bariatric procedures will not be covered when the procedure is considered experimental/investigational for the purpose of weight loss. • Expenses will not be covered when Medical Necessity criteria is not met. • Revision or reversal of a gastric restrictive procedure is limited to failure of the procedure due to complications of anatomic or technical reasons. • Revision of a previous bariatric surgical procedure or conversion to another procedure for inadequate weight loss due to individual noncompliance with postoperative nutrition and exercise recommendations is not a Medically Necessary indication for revision or conversion surgery.
Wellness/Disease Management	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Diabetes education and dietetic support in accordance with Medicare guidelines. • Smoking cessation intervention (counseling). 	

Other Services	
<p>The Plan covers:</p> <ul style="list-style-type: none"> • Autism/applied behavior analysis. • Cognitive rehabilitation when required as a result of Illness or Injury. • Biofeedback for the treatment of urinary incontinence. • Enteral tube feedings with prescription or non-prescription nutritional formulas for nutritional support. • Nutritional support for the treatment of children under the age of one with inborn errors of metabolism. • Medical/surgical treatment for complications resulting from services or supplies that are excluded from coverage under this Plan. • Charges for surcharge fees mandated under the New York Health Care Reform Act (HCRA). • Genetic tests based on evidence that gene being examined is associated with the disease in question and that the test has analytical and clinical validity, subject to Prior Authorization and the following: <ul style="list-style-type: none"> – The result of the test will directly impact clinical decision-making and/or clinical outcome for the individual; and – All laboratories that perform genetic testing must be Clinical Laboratory Improvement Amendments (CLIA) certified. • Care for corns, calluses, bunions or toenails for diabetes mellitus patients. • Cobalamin/Propionate/Homosysteine Metabolism Related Disorders Panel, Sequencing (25 Genes) and Deletion/Duplication (24 Genes) in connection with a potential diagnosis of combined methylmalonic acidemia/homocysteinemia (VB12 Panel). 	<p><u>Exclusions</u> – Expenses will NOT be paid for:</p> <ul style="list-style-type: none"> • Biofeedback for any indication other than urinary incontinence. • HCRA surcharge fees if the act is invalidated or if they are not applicable. • Nutritional support taken orally — except for nutritional support for the treatment of children under the age of one with inborn errors of metabolism. • Nonprescription food supplements. • Standard infant formulas. • Routine foot care. • Direct to consumer genetic testing (such as 23 and Me DNA ancestry testing, for example).

Lead Assay Testing for Residents of Flint, Michigan

The following rules apply to residents of Flint, Michigan who live in ZIP codes 48501, 48502, 48503, 48504, 48505, 48506, or 48507. Children under the age of 6 who reside in one of the listed ZIP codes may obtain lead assay testing without Cost-Sharing at their Ascension Network or National Network facility. Follow-up testing at an Ascension Network or National Network facility is also covered without Cost-Sharing for these children. Adults and children age 6 and older who reside in the listed ZIP codes can receive lead assay testing and follow-up testing without Cost-Sharing at Ascension Network facilities. (Lead testing for these adults and children age 6 and older will be provided at National Network facilities and Out-of-Network facilities, but Cost-Sharing and quantity limitations will apply.) The *Schedule of Benefits* for Flint residents who live in one of the listed ZIP codes is shown below:

Service	Ascension Network		National Network		Out-of-Network
Lead Assay Testing for Children Under Age 6	\$0 Cost-Sharing	No quantity limitation Follow-up testing covered at 100%	\$0 Cost-Sharing	No quantity limitation Follow-up testing covered at 100%	Regular Cost-Sharing and quantity limitation
Lead Assay Testing for Adults and Children Age 6 and Older	\$0 Cost-Sharing	No quantity limitation Follow-up testing covered at 100%	Regular Cost-Sharing and quantity limitation		Regular Cost-Sharing and quantity limitation

Additional Exclusions (General and Specific)

Additional exclusions (general and specific) are listed below.

General Exclusions
<p>The calculation of benefits payable under this Plan will not include or be based upon any charges for:</p> <ul style="list-style-type: none"> • Services or supplies incurred before the date you become a Participant or after eligibility is terminated. • Expenses covered by your prior benefit plan's extension of benefits. • Charges that would not have been billed in the absence of Plan coverage, or which you are not legally obligated to pay or to the extent that the Plan Administrator is prohibited from providing benefits for such charge, by any law or regulation. • Custodial Care. • Services or supplies for which you submit a claim more than 12 months after the expense is incurred. However, if this Plan is the Secondary payer, a claim for benefits can be extended to within 6 months after the date of the Primary payer's payment. In addition, the general 12-month limit on claim submission will not bar the Plan's consideration of a claim if all of the following conditions have been satisfied with respect to such claim: (i) the claimant making the claim must have submitted the claim for payment to at least one other payor within one year after the last date of service to which the claim relates (the "Measurement Date of Service"); and (ii) the claimant must have had a reasonable basis for submitting the claim to the other payor(s); and (iii) submission of the claim to the other payor(s) must not have occurred as a result of the claimant's error or neglect; and (iv) the claimant must submit the claim to the Plan no later than the earlier of (a) 120 days after claimant receives notice from the other payor that the other payor will not pay the claim or is seeking reimbursement of an amount previously paid in connection with the claim, or (b) two years (or three years in the case of a claim that was previously submitted to a governmental payor such as Medicare, Medicaid or TRICARE) after the Measurement Date of Service; and (v) the claimant must provide proof acceptable to the Plan that all four of the foregoing conditions have been satisfied. • Treatment for which benefits are available under Workers' Compensation or services rendered for any occupational Injury or Illness. • Services or supplies furnished by or payable by any government agency; or for benefits furnished, paid for, or required by service in any armed services or as a result of an act of war, whether declared or undeclared. • An Injury incurred while engaged in any activity that violates any federal or state law, including the perpetration of a felony or misdemeanor.

General Exclusions (continued)

- Services or supplies furnished without the recommendation and approval of a Physician acting within the scope of the Physician's license.
- Services or supplies not Medically Necessary to the care and treatment of any Injury or Illness, unless the procedure is specifically covered.
- Care, treatment, services and supplies that are not uniformly and professionally endorsed by the general medical community as standard medical care.
- Professional services, care, treatment and referrals rendered by yourself, by a family member, or by any person who resides with you.
- Services provided by a Christian Science facility, practitioner or nurse.
- Procedures, treatment, services, supplies or drugs not approved by the FDA; or approved by the FDA, but not for the specific condition being treated, except in the case of Off-Label Drug Use; or which are considered as Experimental Treatment or investigative.
- Private Duty Nursing or private duty attendants.
- Treatment or services that were received outside of the United States, its protectorates, Canada or Mexico, except if the treatment is for a Medical Emergency or is provided by a facility or provider that has contracted with the Claims Administrator to provide such treatment or services to Participants.
- Charges for services by dependents with dual medical coverage, who do not follow their Primary plan's criteria, guidelines and networks.
- Services or treatment required by a third party.
- Charges for a provider to appear in court.
- Copying of medical records.
- Services determined not to be a Covered Expense based on Medical Necessity review.
- Expenses that would be inconsistent with the Ethical and Religious Directives for Catholic Health Care Services, as published and revised from time to time by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church.
- Any services and/or supplies that are expressly excluded under one or more applicable policies of the Plan Administrator or the Plan's utilization vendor.
- Charges for, or in connection with, sexual conversion surgery and other services related to gender reassignment or disturbance of gender identification or related sexual impotency so as not to violate the Ethical and Religious Directives for Catholic Health Care Services.
- Charges relating to schooling that is received as part of treatment in an Extended Care Facility, a Residential Treatment Center, or a long-term residential behavioral health therapy program.

Specific Exclusions

The calculation of benefits payable under this Plan will not include or be based upon any charges for:

- Acupuncture or acupressure.
- Abortions, except for operations, treatments, or medications that have as their direct purpose the cure of a proportionately serious pathological condition of a pregnant woman when they cannot be safely postponed until the newborn baby is viable, even if they will result in the death of the unborn baby (for example, early induction of labor).
- Care for corns, calluses, bunions, or toenails except for diabetes mellitus patients.
- Circulating tumor cell tests for metastatic cancer.
- Contraceptive services and devices, except for counseling and instruction in natural family planning and related services, including NaPro technologies.
- Diabetic supplies, as follows: glucose meters, test strips, lancets and lancet devices and diabetic control solutions.

Specific Exclusions (continued)

- Educational testing, therapy, or training.
- Exercise programs.
- Hair replacement including wigs, or hair removal, except when necessitated by hair loss due to chemotherapy or radiation treatment or severe burns to the scalp.
- Hypnotherapy.
- Services or supplies related to assisted reproduction or artificial conception, including without limitation artificial insemination, in vitro fertilization, embryo transfer, services done in preparation for such a procedure or testing to determine the success of such a procedure and as further described in applicable policies of the Plan's utilization vendor.
- Laser or radial keratotomies.
- Multi-fetal Pregnancy reductions.
- Music therapy or reading therapy.
- Orthoptic Training.
- Orthotripsy (Extracorporeal Shock Wave therapy).
- Over-the-counter products, except nutritional formulas for nutritional support delivered by enteral tube feeding.
- Pre-marital, pre-employment, or any examinations required by school, camp, licensing, or any other regulatory purposes, including all related diagnostic testing.
- Penile implants or Durable Medical Equipment, for example, male erection systems, unless Medically Necessary to correct impotence caused by organic disease or Injury.
- Recreational therapy.
- Sensory integration therapy, etc., for Developmental Delay or any other diagnosis.
- Sterilization of either men or women, whether permanent or temporary, except when the direct effect is the cure or alleviation of a present and serious pathology and a simpler treatment is not available.
- Sterilization reversal.
- Ultraviolet therapy or other light therapy, except in the treatment of psoriasis, atopic dermatitis, mycosis fungoides, dyshidrosis, Sezary's disease, vitiligo, Lichen Planus, Actinic Keratosis or for covered Eligible Dependents under the age of one with hyperbilirubinemia.
- Vision correction (examinations, testing and procedures), including eyeglasses and contact lenses, unless the service is eligible under Covered Medical Expenses.
- Quantitative EEG for the treatment of depression.
- E-cigarettes.

Also see the exclusions listed with specific Covered Expenses at the beginning of this *Section 5*.

Section 6: Prior Authorization/Retrospective Authorization Requirements

Certain medical services require Prior Authorization, according to evidence-based clinical guidelines of the Claims Administrator. A Prior Authorization requirement means that you must receive prior approval before obtaining certain medical services or, if the requirements for Retrospective Authorization discussed below are met, within 30 days thereafter. A medical review is performed to determine if the services are Medically Necessary. Your doctor must submit the necessary paperwork. Although your provider submits the paperwork, it is your responsibility to ensure Prior Authorization has been obtained before the service is rendered.

To review a complete and up-to-date list of services that require Prior Authorization, go to <https://mysmarthealth.org/>.

The Plan Administrator will make Prior Authorization determinations only for services that require Prior Authorization. No determinations will be made or opinions regarding coverage offered with respect to any services not specifically requiring Prior Authorization.

Retrospective Authorization Requirements. If you obtain medical services that required Prior Authorization and you or your provider did not seek such Prior Authorization, you or your provider may seek Retrospective Authorization in certain instances. A request for Retrospective Authorization must be submitted by the provider or Participant within 30 days after obtaining the medical services requiring Prior Authorization. The request must (1) include the reason or an explanation as to why the request was not submitted before services were received, and (2) specify that one or more of the following circumstances existed at the time the services were provided:

- Prior to rendering services, the provider and/or facility was unable to identify the health plan to which a request for authorization was to be submitted, the Participant was not able to tell the provider about such insurance coverage, or the provider verified different insurance coverage.
- The Participant required immediate medical services and the provider was unable to anticipate the need for Prior Authorization immediately before or while performing a service.
- The Participant was discharged from a facility and insufficient time existed for institutional or home health care services to receive approval prior to performing a service.

Prior Authorization is required for all inpatient services, certain outpatient procedures, High Tech Radiology Procedures, all cell and gene therapies, and specific high-cost DME. Any Inpatient Hospital admission from an Ascension Network, National Network or Out-of-Network facility for which Prior Authorization or Retrospective Authorization was not obtained will be considered ineligible under the Plan, in which case the claim will be denied and the Participant may file an appeal. Concurrent review will also be performed on all Inpatient Hospital admissions to ensure appropriate length of stay and discharge planning.

A claim for benefits on your behalf will be denied for the services listed in the table below if:

- The required Prior Authorization is not obtained by the requesting provider prior to the date the service is to be rendered or the Retrospective Authorization requirements are not met.
- You fail to abide by the Medical Necessity benefit determination.

With one exception as discussed below, for services that require Prior Authorization, Prior Authorization must be obtained before you receive the care or Retrospective Authorization requirements must be met. This applies to all providers and Health Ministries.

A request for prior approval of services that do not require Prior Authorization and the Plan's voluntary review of and response to such a request will not be treated as a claim for benefits that is subject to the claim and claim review procedures described in *Section 8*.

These requirements do not apply to a person covered by Medicare if Medicare is the Primary payer.

List of Services Requiring Prior Authorization	
This list applies to all Health Ministries and all providers. Other services may require Prior Authorization. To review a complete and up-to-date list of services that require Prior Authorization, go to the "Information Center" on https://mysmarthealth.org/ and click on "Prior Authorization." For specific details, you can also click on "Prior authorization code list" or call ABS at 888-492-6811 to speak to a customer service representative.	
Inpatient admissions/services	<ul style="list-style-type: none"> • Inpatient Hospital (medical and surgical). • Acute inpatient rehabilitation. • Long-term acute care (LTAC). • Skilled nursing facility (SNF).
Outpatient services	<ul style="list-style-type: none"> • Physical/occupational/speech therapy - requires authorization after 60 combined visits. • Sleep studies provided in a facility.
Behavioral health services	<ul style="list-style-type: none"> • Inpatient admissions. • Residential treatment center (RTC) admissions. • Neuropsychological testing.
High Tech Radiology Procedure	<ul style="list-style-type: none"> • PET, MRI, MRA, etc. • Cardiac Nuclear Imaging.
Genetic Testing	<ul style="list-style-type: none"> • All genetic laboratory testing.
Medical Benefit/ Medical Specialty Drugs	<ul style="list-style-type: none"> • Physician office-based drug infusions. • Office administered medical benefit drugs including injectables and oral chemotherapy drugs. • Hospital outpatient drug infusions. • Home infusions for medical specialty drugs.

List of Services Requiring Prior Authorization

This list applies to all Health Ministries and all providers. Other services may require Prior Authorization. **To review a complete and up-to-date list of services that require Prior Authorization, go to the “Information Center” on <https://mysmarthealth.org/> and click on “Prior Authorization.”** For specific details, you can also click on “Prior authorization code list” or call ABS at **888-492-6811** to speak to a customer service representative.

Procedures	<ul style="list-style-type: none"> • Bronchial thermoplasty. • Carticel (ACI), osteochondral allograft and autograft transplantations. • Cochlear implant surgery; associated supplies/bone-anchored (osseointegrated) hearing aids; implantable bone conduction hearing aids. • Bariatric surgery. • Uvulopalatopharyngoplasty (UPPP), including laser-assisted procedures. • Spinal surgeries. • Hypoglossal Nerve Stimulation. • Vein procedures (ablation, ligation, stripping, sclerotherapy etc.).
Reconstructive procedures/surgeries and potentially cosmetic procedures	<ul style="list-style-type: none"> • Blepharoplasty/ptosis repair. • Bone graft, genioplasty and mentoplasty. • Breast: reconstruction, reduction, augmentation, mammoplasty, mastopexy, insertion and removal of breast implants. • Canthopexy/canthoplasty. • Cervicoplasty. • Chemical peels. • Dermabrasion. • Excision of excessive skin and/or subcutaneous tissue. • Genetically and bio-engineered skin substitutes for wound care. • Injectable dermal fillers. • Keloid removal. • Lipectomy, liposuction, or any other excess fat-removal procedure. • Otoplasty. • Rhinoplasty. • Rhytidectomy. • Scar revision. • Skin closures including skin grafts, skin flaps, tissue grafts.
Any Procedure/Device/Service that may be Potentially Experimental/Investigational	<ul style="list-style-type: none"> • New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments.

List of Services Requiring Prior Authorization	
<p>This list applies to all Health Ministries and all providers. Other services may require Prior Authorization. To review a complete and up-to-date list of services that require Prior Authorization, go to the “Information Center” on https://mysmarthealth.org/ and click on “Prior Authorization.” For specific details, you can also click on “Prior authorization code list” or call ABS at 888-492-6811 to speak to a customer service representative.</p>	
Customized Orthoses and Prosthetics (Including Accessories/Components)	<ul style="list-style-type: none"> • Custom ankle-foot orthoses. • Custom knee-ankle-foot orthoses. • Custom knee braces. • Custom limb prosthetics including accessories/components.
Air Ambulance Transport Services	<ul style="list-style-type: none"> • Prior Authorization is required all inter-facility or hospital to hospital air transport both fixed wing and rotor wing aircraft. • Elective/Non-emergency air ambulance services.
Durable Medical Equipment (DME) See CPT code list Hyperbaric Oxygen/Chamber therapy.	
Proton beam therapy	
Transplant services – including evaluation, except for corneal transplants	
Cell/Gene Therapy	

For details about claim and review procedures used when Prior Authorization is required before obtaining the medical care, see “Pre-Service Claims” and “Time-Sensitive Claims” in *Section 8*.

Section 7: Care Management

Ascension may institute care management programs as part of SmartHealth in certain situations. Care management is a collaborative process in which teams made up of experienced nurses, counselors, pharmacists, spiritual care chaplains, health coaches, social workers and community health workers work collaboratively with a Participant to assess, plan, facilitate, coordinate, monitor and evaluate options and services to meet an individual's comprehensive health needs and achieve the individual's health care goals. Care management is a set of activities intended to improve patient care and reduce the need for medical services by enhancing coordination of care, eliminating duplication, and helping patients and caregivers more effectively manage their health conditions.

Care managers may assess a Participant's diagnosis, health history, current needs and treatment plan in order to determine the appropriate level of involvement. Involvement may include:

- On-going telephone contact with the Participant or a family member.
- Assisting providers and Participants in coordinating ancillary services.
- Education about the Illness or Injury.
- Facilitating access to community services and resources.
- Discharge planning.
- Utilization management.

Referral into care management for social needs or complex or unstable medical conditions can be made by:

- Calling the SmartHealth Customer Service telephone number on the back of your SmartHealth ID card.
- Calling Ascension Care Management directly at 855-288-6747.
- Emailing acmmembers@ascension.org.

Section 8: Claims and Review Procedures

For purposes of these Claims and Review Procedures, the entity or individual that is responsible for determining a claim is always referred to as the “Claims Administrator.” This reference applies to the Plan Administrator or a third party hired by the Plan Administrator. The Claims Administrator who reviews a denied claim may be different than the Claims Administrator who reviews the initial claim. Where applicable in connection with Pre-Service Claims, a reference to the Claims Administrator shall be deemed to include the Plan’s utilization vendor.

The Plan’s procedures for filing and reviewing claims depends upon the Claims Administrator and the type of claim filed: Pre-Service Claims, Time-Sensitive Claims, Post-Service Claims, Concurrent Care Claims and Other Claims. Claims may be filed and a review of any denied claim may be sought by you, your doctor, pharmacist or other healthcare provider, or your authorized representative (see *Your Contact Information* at the beginning of this SPD).

All claims filed, regardless of type, must be filed with the Claims Administrator within 12 months of the date the expense was incurred.

Claims Procedures

In most cases, your doctor, pharmacist or other healthcare provider will file claims on your behalf following the procedures described here. However, in other cases, (for example, if you use an Out-of-Network provider), you may have to file claims following these procedures.

The Participant’s doctor, pharmacist, or other health care provider with knowledge of the Participant’s condition will automatically be treated as a Participant’s authorized representative for the purpose of filing or appealing a claim. A Participant, who is an Eligible Associate, will automatically be treated as an authorized representative of such Participant’s Eligible Dependents for the purpose of receiving explanations of benefits and filing or appealing a claim; provided, however, that an adult Eligible Dependent may opt out of the rule in this sentence by notifying the Plan Administrator in writing (and, to the extent required by the Plan Administrator, completing any necessary forms). A Participant may also appoint an authorized representative (using forms available from the Claims Administrator or Plan Administrator), to deal with the Plan on the Participant’s behalf with respect to any benefit claim that the Participant files or any review of a denied claim that the Participant chooses to pursue. Once the Participant has appointed an authorized representative, the Claims Administrator will communicate directly with that representative, and will not also inform the Participant of the status or outcome of the claim. The Plan will recognize only the person that the Participant has authorized on the last dated form filed with the Plan. If no representative is appointed, the Claims Administrator will communicate with the Participant directly. Claims may be filed, and a review of any denied claim may be sought, by any Participant or any properly authorized representative.

Pre-Service Claims

A Pre-Service Claim is a request that is not time-sensitive for a medical service that requires Prior Authorization (as described in *Section 6*) or any other step required for the benefit to be paid. In most cases, your doctor will submit the Pre-Service Claim. The claim and all necessary information may be submitted orally or in writing to the Claims Administrator (see *Your Contact Information* at the beginning of this SPD).

A Pre-Service Claim will be processed as follows:

- After receiving the claim, the Claims Administrator will respond no later than 15 days after receiving the claim.
- If a claim has not been filed properly, you (or your healthcare provider) will be notified within 5 days of the steps to take to properly file the claim.
- If a claim has been properly filed, but is lacking sufficient information, you will be notified within 15 days of the information or documents that are needed, and the Claims Administrator will request an extension of time to decide the claim.
- You must provide the additional information or documentation within 45 days from the date you receive the notice. Otherwise, the claim will be decided without the information. If the Claims Administrator timely receives the additional information, the Claims Administrator will have 15 days to decide whether to authorize the treatment, service or procedure.
- Within 15 days of receiving the claim, the Claims Administrator may also ask for an extension of time to decide a claim due to reasons that are beyond the control of the Claims Administrator. The notice will explain why the extension is needed and the date by which the claim will be decided. The claim will be decided within a reasonable period of time appropriate to the medical circumstances, but no more than 30 days from the date the claim was received.

Approval of a Pre-Service Claim or Time-Sensitive Claim serves only to meet the Plan's Prior Authorization requirement (see *Section 6* for details). Prior Authorization is not a guarantee that the claim will be paid in full, as there may be other reasons to deny the claim. Once the care is provided, the provider's bill will be processed as a Post-Service Claim.

Time-Sensitive Claims

A Time-Sensitive Claim is a Pre-Service Claim where applying the standard timeframes for processing could seriously jeopardize your life or health or ability to regain maximum function, or cause severe pain that cannot be adequately managed without the treatment, service or procedure that is the subject of the claim.

If your doctor informs the Claims Administrator that the claim is a Time-Sensitive Claim, the claim will be treated as a Time-Sensitive Claim. Otherwise, the Plan will determine whether a claim is a Time-Sensitive Claim using the judgment of a prudent layperson with average knowledge of health and medicine.

In most cases, your doctor will submit the Time-Sensitive Claim on your behalf. The claim and all necessary information may be submitted orally or in writing to the Claims Administrator (see *Your Contact Information* at the beginning of this SPD).

After receiving the Time-Sensitive Claim,

- The Claims Administrator will notify you (or your healthcare provider) of its determination as soon as possible, but no later than 72 hours after receiving the claim.
- If the claim is improperly filed or lacks specific information, the Claims Administrator will notify you within 24 hours after receiving the claim. The notice will describe the specific information

necessary to complete the claim and you will have 48 hours to provide the requested information.

- The claim will be decided within 48 hours after receiving the requested information or, if earlier, the end of the 48-hour period allowed for you to provide the additional information.

Other than requests for additional information, there are no extensions of time for determining Time-Sensitive Claims.

Concurrent Care Claims

If you have been approved for a course of treatment under the Plan, you (or your healthcare provider) may file a Concurrent Care Claim with the Claims Administrator (see *Your Contact Information* at the beginning of this SPD) if:

- It is determined that coverage for the course of treatment is to be reduced or terminated before the treatment is completed and you seek to restore the remainder of the treatment regimen, or
- You wish to extend the course of treatment.

If the Concurrent Care Claim is a Time-Sensitive Claim, it will be decided by the Claims Administrator as soon as possible but no later than 24 hours after it was received, provided that the claim was filed at least 24 hours prior to the end of the course of treatment originally approved.

All other Concurrent Claims will be decided quickly enough so that you will have sufficient time to seek review of any claim denial before the course of treatment is scheduled to terminate.

Post-Service Claims

A Post-Service Claim is a request for the Plan to pay for medical expenses already incurred or supplies already purchased.

The provider will submit Post-Service Claims on your behalf. If you receive a bill directly from a provider, or pay for services or supplies directly, you may file the claim yourself following the procedures in the box below.

Typically, the Claims Administrator will decide Post-Service Claims within 30 days of receipt. Otherwise, these steps will be followed:

- If the information provided is insufficient to determine the claim, the Claims Administrator will notify you (or your authorized representative) within 30 days of the receipt of the claim of the additional information needed and will request an extension of time in which to decide the claim.

If you need to file a Post-Service Claim, complete the *Post-Service and Second-Level Appeal Request Form*, and submit it, along with any medical records, EOBs, bills and other documentation that supports your claim. Be sure to include the following information:

- Group number provided on the front of your SmartHealth ID card.
- Name, address and enrollee ID of the Eligible Associate and patient.
- Name, address and tax identification number (if available) of the provider.
- Claim number, date of service and description of service being disputed.

This form is available by going online to <https://mysmarthealth.org/>, selecting your Health Ministry and then **Information Center**. Under the **Appeals** section, select the *Post-Service and Second-Level Appeal Request Form*. You may fax or mail the completed form and accompanying documentation as directed on the form or to the address or fax noted in the *Your Contact Information* section at the beginning of this SPD.

- You will have 45 days from the date you receive the notice to provide the information or the claim will be decided without the information.
- If the additional information is timely submitted, the Claims Administrator will have 15 days to decide whether and to what extent the expenses are payable as covered benefits under the Plan.
- Within 30 days of receipt of the claim, the Claims Administrator may also ask for an extension of time to decide a Post-Service Claim for reasons beyond the control of the Claims Administrator. The claim will be decided no more than 45 days from the date the claim was received.

Explanation of Benefits or Initial Claim Denial

For Pre-Service, Concurrent Care and Time-Sensitive Claims, you (or your authorized representative) will be notified whether the claim is granted or denied, in whole or in part. For Post-Service Claims, you may only be notified if the claim is denied.

Notice of Initial Claim Denial

If the initial claim is denied, in whole or in part, the Claims Administrator will provide to you (or your authorized representative) in writing or electronically (for example, by e-mail), a Notice of Initial Claim Denial. However, for a Time-Sensitive Claim, a call may be made first followed by a written notice within 3 days.

The notice will explain the reasons for the denial of the initial claim, including the Plan provisions or rules on which the denial is based, along with the denial code and its corresponding meaning, and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning. It will include a description of any additional materials needed to complete the claim and the time limits for providing them.

An “initial claim denial” is any adverse benefit determination, such as:

- A determination that the Plan will not pay the total amount of expenses, and you must pay a Cost-Share.
- Any determination that the item or service was experimental or investigational or was not Medically Necessary or appropriate.
- A “rescission” of coverage, as defined in the Patient Protection and Affordable Care Act and related regulations or guidance (for example, a cancellation or discontinuance of coverage that has retroactive effect – other than a retroactive cancellation due to a failure to timely pay required contributions).

It will also explain if the adverse benefit determination was based on medical judgment (for example, if it was determined that the treatment was Experimental Treatment or not Medically Necessary). The notice will either include an explanation of the scientific or clinical judgment upon which the decision was based or will inform you of your right to obtain copies of a written explanation.

Finally, the notice will explain the Plan’s internal and external review procedures, including time limits and your right to receive copies of documents that the Claims Administrator relied upon in making the adverse benefit determination and your right to bring a civil action in court under ERISA if your claim is denied again on appeal.

Internal Appeal Process

You may contact a claims service representative with the Claims Administrator (see *Your Contact Information* at the beginning of this SPD) if you have questions or concerns about any Notice of Initial Claim Denial. If your question or concern remains unresolved, you have the right to submit a request for an internal appeal.

Submitting an Internal Appeal

You (or your authorized representative) must file an internal appeal of an initial claim denial within 180 days after receiving the Notice of Initial Claim Denial. If an appeal is not timely filed, the Participant will have failed to exhaust the Participant's administrative remedies and will be given no further opportunities to file an appeal.

In making your appeal, you should explain all of the reasons why you believe the claim should not have been denied and provide any additional information, materials or documentation supporting your claim.

- For *Time-Sensitive Claims*, you may submit a request for an expedited review, along with all necessary information, by telephone, facsimile or email.
- For *Pre-Service, Post-Service and Concurrent Care Claims*, you must submit the appeal in writing, either by mail, facsimile, or email (not by telephone).
- For *Concurrent Care Claims*, you should submit the review in time to continue the course of treatment.
- *First-level internal appeals of Pre-Service, Concurrent Care or Time-Sensitive Claims* will be reviewed by the Plan's utilization vendor (if the denial was based on Medical Necessity), by ABS (if the denial was not based on Medical Necessity), or by the Plan's applicable Claims Administrator (for a denial of a prescription drug claim).
- *First-level internal appeals of Post-Service Claims* will be reviewed by the SmartHealth Appeals Committee.

The Plan will provide, upon request, sufficient information relating to the voluntary level of appeal to enable you to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including:

- A statement that the decision as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on your rights to any other benefits under the Plan.
- Information about the applicable rules, your right to representation, the process for selecting the decision maker, and the circumstances, if any, that may affect the impartiality of the decision maker, such as any financial or personal interests in the result or any past present relationship with any party to the review process.

The individuals who review your claim appeal will not be the same persons, or report to the same persons, who made the initial determination. They will be looking at the claim as if it were being examined for the first time.

They will also consult with an appropriate medical expert if the initial claim determination was based on medical judgment (for example, an assessment that a particular treatment, drug or other item was experimental or not Medically Necessary). A record of any new medical consultation will become a part of the claim file.

Upon written request, you (or your authorized representative) will be provided reasonable access to all documents, records and other information relevant to the claim appeal. You will have the opportunity to review the claim file and present evidence and testimony.

In addition, if the Claims Administrator considers any new evidence in connection with your claim, or bases an appeal decision on any new or additional rationale, the Claims Administrator will provide the new information in enough time for you to respond before the deadline.

Internal Appeal Review for Pre-Service, Concurrent Care and Time-Sensitive Claims

The Plan has one required level of internal review and one voluntary level of internal review for Pre-Service, Concurrent Care and Time-Sensitive Claims.

First-Level Internal Appeal. You (or your authorized representative) should timely send all the information that supports the appeal to the Plan's utilization vendor (if the denial was based on Medical Necessity), to ABS (if the denial was not based on Medical Necessity), or to the Plan's applicable Claims Administrator (for a denial of a prescription drug claim). Please see *Your Contact Information* at the beginning of this SPD. The committee (or Claims Administrator, as applicable) will make a decision as soon as possible but no later than these deadlines:

- Time-Sensitive Claim – no later than 72 hours after receiving the request for a review.
- Pre-Service Claim – no later than 30 days after receiving the request for a review.
- Concurrent Care Claims – within 72 hours if it is a Time-Sensitive Claim or within 30 days if it is a Pre-Service Claim.

Second-Level Internal Appeal. If the first-level internal appeal of a Pre-Service, Concurrent Care, or Time-Sensitive Claim is denied, you (or your authorized representative) have 60 days from the date you receive the denial to submit a request for a voluntary second-level review.

The SmartHealth Advisory Committee (see *Your Contact Information* at the beginning of this SPD), will review second-level internal appeals. The committee will make a decision within 60 days of receiving your request. If a second-level internal appeal is denied for different reasons from the reasons given for the first-level internal appeal, such an appeal will be treated as though it is a first-level review and not a second-level review.

A request for a voluntary second-level review of a Pre-Service Claim, Concurrent Care, or Time-Sensitive Claim should be made in the same manner as for filing a request for a first-level review.

A second-level review is not required.

- If you decide not to proceed with the voluntary second-level review of a Pre-Service, Concurrent Care, or Time-Sensitive Claims, the Claims Administrator may not assert that you failed to exhaust the administrative remedies under the Plan.
- If you decide to proceed with the voluntary second-level review, any applicable limitations period will be tolled while the voluntary second-level review is pending. You will not be charged any fees or costs in connection with any second-level internal appeal request.

You may request information about the voluntary level of appeal so that you may make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal. Your decision will have no effect on your rights to any other benefits under the Plan.

Internal Appeal Review for Post-Service Claims

This Plan has one required level of internal review and one voluntary level of internal review for Post-Service Claims.

First-Level Internal Appeal. The SmartHealth Appeals Committee will review first-level internal appeals of an initial denial of a Post-Service Claim. However, if your appeal relates to prescription drugs, you (or your authorized representative) should timely send all the information that supports the appeal to the Plan's applicable Claims Administrator (see *Your Contact Information* at the beginning of this SPD). The committee (or Claims Administrator, as applicable) will make a decision no later than 60 days after receiving the request.

Second-Level Internal Appeal. If you receive a denial of the first-level internal appeal of a Post-Service Claim and are still in disagreement with the determination, you may seek a second-level review within 60 days after receipt of the denial of the first-level internal appeal. A second-level review is not required.

The request for a second-level internal review of a Post-Service Claim should be made in the same manner as for filing the request for a first-level review and should be made to the SmartHealth Advisory Committee. The committee will make a decision within 60 days of the receipt of the request. If a second-level internal appeal is denied for reasons that are different from reasons given for the first-level internal appeal, such an appeal will be treated as though it is a first-level review and not a second-level review.

Internal Appeal Review for Non-Covered Benefit Claims

Non-Covered Benefit Claims are claims for procedures, treatments or services that are not listed under the *Schedule of Benefits* or as Covered Expenses or are listed as exclusions.

The Plan has one required level of internal review and one voluntary level of internal review for all Non-Covered Benefit Claims.

First-level internal appeal of Non-Covered Benefit Claims are reviewed by the SmartHealth Appeals Committee or in the event of a denial of a prescription drug claim, the Plan's applicable Claims Administrator (see *Your Contact Information* at the beginning of this SPD). The decision on review of a Non-Covered Benefit Claim will be made within 30 days after the receipt of the appeal. Any second-level voluntary appeals that you choose to make must be requested within 60 days after receiving a denial (including a partial denial) of the first-level internal appeal. The second-level review decision will be made within 60 days of the receipt of the appeal. Second-level voluntary appeals are reviewed by the SmartHealth Advisory Committee (which also reviews second-level voluntary appeals of Pre-Service Claims).

Other Benefit Determinations

If you make a claim for a benefit determination that is not a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Claim or a Time-Sensitive Claim, (for example, a claim regarding benefit eligibility,) the claim will be handled as a Post-Service Claim, and, if necessary, the SmartHealth Advisory Committee will review second-level internal appeals.

Notification of Decision on Internal Appeal Reviews

If the denial of a claim is appealed, in whole or in part, the applicable Committee will notify you (or your authorized representative) in writing or electronically (for example, by e-mail) of each decision on internal review, whether favorable or adverse. However, for a Time-Sensitive Claim, a call may be made first followed by a written notice within 3 days.

The notice of denial on appeal will explain the reasons for the denial of the initial claim, including the Plan provisions or rules, guidelines, or protocols on which the denial is based.

It will also explain if the adverse benefit determination was based on medical judgment (for example, an assessment that the treatment was experimental or not Medically Necessary). The notice will either include an explanation of the scientific or clinical judgment upon which the decision was based or will inform you of your right to obtain copies of a written explanation.

The notice will further explain your right to receive copies of documents that the applicable Committee relied upon in making the adverse benefit determination and will include a statement that you have the right to bring a civil action in court under ERISA, or if available, file a claim for external review.

Finally, the notice will include an explanation of voluntary levels of review which the Plan makes available, if any, including applicable time limits for electing such voluntary review procedures and a statement describing the availability, upon request, of the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning.

For Pre-Service, Concurrent Care, Time-Sensitive, Post-Service and Non-Covered Benefit Claims, the decision of the Claims Administrator on the required levels of review is final. You may, however, elect to proceed to a second, voluntary level of review for these claims.

You (or your required representative) may bring no action against the Plan, the Plan Administrator or a Plan fiduciary in any court unless the claims and appeals procedures have been fully exhausted (except for voluntary appeals).

Any individual or entity asserting any action under ERISA must do so, if at all, within one year after the date that the “cause of action” accrued. A “cause of action” will be deemed to accrue on the earliest of the following: (i) the date that a claimant exhausted the claimant’s administrative remedies under the Plan (except for voluntary appeals); (ii) the date that the Plan Administrator, in response to a written request, fails to produce documents in the time or manner required by ERISA; (iii) the date on which the claimant first was advised that the claimant was an independent contractor; or (iv) the date when the claimant first knew or should have known of the action allegedly violating 29 U.S.C. Section 1140. Failure to bring an action in court within this time frame will preclude any claimant from bringing any action in court.

If, however, the Claims Administrator or applicable Committee fails to comply with any of the deadlines described above or fails to adequately inform you of your procedural rights, you may treat these procedures as having been completed, and file a claim in court, or, if available, file a claim for external review. You must file a claim in court within one year of the date you knew, or should have known, of the Claims Administrator’s or applicable Committee’s material failure to comply with these procedures.

External Appeals Process

In cases where a denial is upheld in whole or in part through the internal appeal review process above, you may submit an appeal through the external review process for cases involving medical judgment or rescission of coverage.

Request for External Review

You must file a request for an external review within 4 months after the date of receipt of a notice of an adverse benefit determination or final internal adverse benefit determination, but only in cases involving medical judgment or rescission of coverage. (If there is no corresponding date 4 months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1.) If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Preliminary Review

Within 5 business days following the date of receipt of the external review request, the SmartHealth Appeals Coordinator will complete a preliminary review of the request to determine if your request is eligible for an external review, and if so, if your request is complete.

The Plan will determine whether:

- You are (or were) covered under the Plan at the time the healthcare item or service was requested or, in the case of a retrospective review, were covered under the Plan at the time the healthcare item or service was provided, and that the adverse benefit determination does not relate to your failure to meet eligibility requirements (for example, worker classification or similar determination);
- You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeals process; and
- You have provided all the information and forms required to process an external review.

The Plan will notify you in writing within 1 business day following the preliminary review.

If the request is complete but not eligible for external review, the notification must include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration – toll-free number **866-444-EBSA (866-444-3272)**.

If you are eligible but the request is not complete, the written notification must describe the information needed to complete the request, and the claimant will be permitted to perfect the request for external review within the 4-month filing period or within the 48-hour period following the receipt of the notification, whichever is later.

Referral to Independent Review Organization

After receiving a timely and complete request for external review, the Plan will assign an independent review organization (IRO) that is accredited by the Utilization Review Accreditation Committee ("URAC") or by a similar nationally recognized accrediting organization to conduct the external review.

- The assigned IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

- Within 5 business days after assigning the IRO, the Plan must provide to the IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within 1 business day after making the decision, the IRO must notify the claimant and the Plan.
- The IRO will timely notify you in writing of the request's eligibility and acceptance for external review. This notice will state that you have 10 business days to submit additional information which the IRO must consider. If you submit information later than that, the IRO may choose to consider it but is not required to do so.
- Upon receipt of any information submitted by you, the IRO must within 1 business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the Plan decides to reverse its adverse determination and provide coverage or payment. Within 1 business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the IRO must terminate the external review at that point.
- The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim from the beginning and will 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 IRO may consider the following to the extent the information and documents are available:
 - The claimant's medical records.
 - The attending healthcare professional's recommendation.
 - Reports from appropriate healthcare professionals and other documents submitted by the Plan or claimant or claimant's treating provider.
 - The terms of the Plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.
 - 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.
 - Any applicable clinical review criteria developed and used by the Plan, the criteria are inconsistent with the terms of the Plan or with applicable law.
 - The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available and the clinical reviewer or reviewers consider appropriate.
 - The IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to you (the claimant) and the Plan.

Reversal of Plan's Decision

Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Request for Expedited External Review

The Plan allows you to request an expedited *external* review if you:

- Have filed a request for an expedited internal appeal of an adverse benefit determination, and it involves a medical condition for which the timeframe for completion of an expedited internal appeal under the typical timeframe would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or
- Have received 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 your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or healthcare 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 will determine whether the request meets the requirements described above and will immediately send a notice to you regarding its eligibility determination.

Then, the Plan will assign an IRO consistent with the requirements described above for standard review. The Plan will provide (electronically or by telephone or facsimile or any other available expeditious method) to the IRO all necessary documents and information that the Plan considered in making the adverse benefit determination or final internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the IRO must review the claim as if it is being reviewed for the first time and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

The Plan requires the IRO to provide notice of the final external review decision as expeditiously as your medical condition or circumstances require, but no later than 72 hours after the IRO receives the request for an expedited external review. The IRO may initially inform you of its decision by phone, but must provide written confirmation of the decision to you (as the claimant) and the Plan within 48 hours after the date of providing that notice.

Various notices to claimants that are part of the appeals and external review process are deemed to be received by the claimant three business days after the notices were deposited into the United States mail, with first class postage prepaid and addressed to the intended recipient.

Authority of Claims and Appeals Administrators

The Claims Administrator, the Plan's utilization vendor, the SmartHealth Appeals Committee and the SmartHealth Advisory Committee are appointed by the Plan Administrator and have the discretionary authority and power to make factual findings, to fix omissions, to resolve Plan ambiguities, to construe the terms of the Plan and to make benefit eligibility determinations with respect to the benefit option for which that claims fiduciary is appointed. Each committee has the power to delegate all or part of its discretionary authority to a person, persons or sub-committee, which will have the power to act on behalf of the committee to the extent of the committee's delegation of authority. In addition, the interpretation of all Plan provisions, and the determination of whether a Participant or beneficiary is entitled to any benefit under the terms of the Plan, will be exercised by the Plan Administrator in its sole discretion.

Limitations Period for Legal Action

No lawsuit can be brought under the Plan prior to your exhausting the Plan's administrative claim and appeal procedures. No lawsuit to recover benefits can be commenced or maintained after the date that is 12 months after the date on which the claimant is notified of a final decision regarding a claim under the Plan's claim and review procedures.

Section 9: Your ERISA Rights

As a Participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated SPD. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Your Group Health Coverage

- Continue healthcare coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review *Section 11* of this SPD and the documents governing the Plan for the rules that explain your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries. No one, including your Participating Employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan Administrator's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that the Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the insurance carrier, Plan Administrator or Claims Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

Section 10: Privacy Practice Notice

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

Responsibilities

Ascension takes the privacy of your health information seriously. We are required by law to maintain that privacy, to provide you with this Notice of Privacy Practices ("Notice"), and to notify affected individuals following a breach of unsecured protected health information. This Notice is provided to tell you about our duties and practices with respect to your information. We are required to abide by the terms of this Notice currently in effect.

The Notice applies to the Ascension SmartHealth Medical Plan ("Plan") only.

How We May Use and Disclose Your Health Information

The following categories describe different ways that we use and disclose health information. For each category we explain what we mean and give some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- **To the Plan Sponsor.** The Plan may disclose your information to the Plan Sponsor, which is your employer, in certain situations, and may permit any health insurance company or HMO with whom you have benefits to disclose your information to the Plan Sponsor. The plan documents that regulate the Plan must restrict how the Plan Sponsor uses and discloses your information, however.

In addition, the Plan may disclose your "summary health information" to the Plan Sponsor to obtain premium bids from health plans for the Plan's coverage or to amend the Plan. "Summary health information" means your information that identifies you and summarizes your claims history, expenses or types, but the information will not identify you any more specifically than your zip code.

Also, the Plan may disclose to the Plan Sponsor whether or not you are participating in the Plan or are enrolled or disenrolled.

The Plan may disclose your information to the Plan Sponsor to carry out Plan administration functions.

The Plan may not disclose your information to the Plan Sponsor for the purpose of employment-related actions or decisions or in connection with any other employee benefit plan of the Plan Sponsor.

- **For Payment.** We may use and disclose your health information for the purpose of:
 - Obtaining premiums or to determine or fulfill the responsibility for coverage and provision of benefits under the Plan.
 - Coordination of benefits or the determination of Cost-Sharing amounts.
 - Adjudication or subrogation of health benefit claims.
 - Processing claims.

- Billing.
- Claims management.
- Collection activities.
- Obtaining payment under a contract for reinsurance (including stop-loss insurance and excess of loss insurance).
- Review of health care services with respect to Medical Necessity.
- Coverage under a health plan.
- Appropriateness of care, or justification of charges for the treatment and services provided to you.
- Utilization review activities, including precertification and preauthorization of services, and concurrent and retrospective review of services.
- Disclosure to consumer reporting agencies of any of the following protected health information: name and address, date of birth, social security number, payment history, account number, name and address of any relevant health care provider and/or health plan.

We may also provide your information to another entity for its payment activities.

We may also disclose your information to another entity for certain health care operations of that entity.

Some examples of the uses and disclosures for payment include the following. (Please note that, as is the case with the other examples in this Notice, these examples are merely a few of the many types of uses and disclosures that might be made.) The Plan will disclose your health information to the Plan's third-party administrator (TPA) so the TPA can process claims you make under the Plan. The Plan also may disclose such information to another health plan in order to determine which plan (this Plan or the other plan) should pay such claims. Health information, such as your medical history, also could be disclosed to your health care providers in order to determine whether a particular course of treatment is experimental, investigational or Medically Necessary.

- **For Treatment.** Unlike health care providers, the Plan does not actually provide treatment. Instead, the Plan is a mechanism to provide payment for or reimbursement of the cost of health care. Although the Plan does not actually provide treatment, it may disclose health information to physicians or other health care providers in order to enable them to treat you.

For example, disease management services may be provided through the Plan, in which case health information may be disclosed in order to enable your health care providers to deliver such services. Or, the Plan may disclose to your primary care physician the name of a specialist who is treating you so that they may coordinate your care.

- **For Health Care Operations.** We may use and disclose your health information for health care operations including:
 - Conducting quality assessment and improvement activities – including outcomes evaluation and development of clinical guidelines.
 - Population-based activities relating to improving health or reducing health care costs.
 - Reviewing the competence or qualifications of health care professionals.

- Evaluating practitioner and provider performance, and Plan performance.
 - Accreditation, certification, licensing, or credentialing activities.
 - Underwriting, premium rating and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss Insurance).
 - Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs.
 - Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies.
 - Business management and general administrative activities of the Plan, including, but not limited to: management activities relating to implementation of and compliance with the requirements of the HIPAA regulations; customer service; resolution of internal grievances consistent with the applicable requirements of the HIPAA regulations, creating de-identified health information, or a limited data set.
 - Examples of the foregoing include the following: The Plan may engage in activities in which the quality of care provided under the Plan is evaluated and, in doing so, may use health information or disclose such information to an organization performing the evaluation. The Plan may submit health information to an insurance company that provides “stop-loss” coverage to Ascension. The Plan may provide health information to auditors who review operations of the Plan in order to ensure that claims are being paid properly and that no fraud or abuse is occurring in connection with the Plan.
- **Incidental Uses and Disclosures.** We may occasionally inadvertently use or disclose your medical information when such use or disclosure is incident to another use or disclosure that is permitted or required by law. For example, while we have safeguards in place to protect against others overhearing our conversations that take place between doctors or nurses and a Plan representative, there may be times that such conversations are in fact overheard. Please be assured, however, that we have appropriate safeguards in place to avoid such situations, and others, as much as possible.
 - **Disclosures to You.** Upon a request by you, we may use or disclose your medical information in accordance with your request.
 - **Limited Data Sets.** We may use or disclose certain parts of your medical information, called a “limited data set,” for purposes of research, public health reasons or for our health care operations. We would disclose a limited data set only to third parties who have provided us with satisfactory assurances that they will use or disclose your medical information only for limited purposes.
 - **Disclosures to the Secretary of Health and Human Services.** We might be required by law to disclose your medical information to the Secretary of the Department of Health and Human Services, or his or her designee, in the case of a compliance review to determine whether we are complying with privacy laws.

- **De-Identified Information.** We may use your medical information, or disclose it to a third party whom we have hired, to create information that does not identify you in any way. Once we have de-identified your information, it can be used or disclosed in any way according to law.
- **As Required by Law.** We will disclose your health information when required to do so by federal, state or local law.
- **Marketing.** The Plan may use or disclose your information to make communications to you about its products or services or benefits, as well as to describe its network or details of the Plan. If health-related products or services add value to the Plan's benefits, but are not part of it, and are available only to an enrollee of the Plan, we may use or disclose your information to describe such products or services. In addition, we may use or disclose your information for marketing if communications are made face-to-face or if they are in the form of a promotional gift of little value.
- **Health Oversight Activities.** We may disclose your health information to a health oversight agency for activities authorized by law. These oversight activities might include audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Judicial Purposes.** We may disclose your health information in response to a court or administrative order. We may also disclose your health information 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.
- **Military and Veterans.** If you are a member of the armed forces, we may release your health information as required by military command authorities. We may also release health information about foreign military personnel to the appropriate foreign military authority.
- **National Security and Intelligence Activities.** We may release your health information to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.
- **Protective Services for the President and Others.** We may disclose your health information to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.
- **Treatment Alternatives and Health-Related Benefits.** We may use and disclose your health information to tell you about or recommend possible health-related benefits or services that may be of interest to you.
- **Individuals Involved in Payment for Your Care.** We may release health information about you to your responsible party, friend or family member who is involved with payment for your care.
- **Third Parties.** The Plan may disclose your information to a third party that performs services on behalf of the Plan, such as its third-party administrator, but only if the third party signs a contract agreeing to protect your information.
 - **Disclosures of Records Containing Drug or Alcohol Abuse Information.** Because of federal law, we will not release your medical information if it contains information about drug or alcohol abuse without your written permission except in very limited situations.

Uses and Disclosures for Which Authorization is Required

The following uses and disclosures of your health information require your valid authorization:

- **Psychotherapy Notes.** We must obtain your authorization for most uses or disclosures of psychotherapy notes relating to you.
- **Marketing.** We must obtain your authorization for marketing unless the communication is in the form of a face-to-face communication made by the Plan to you or a promotional gift of nominal value provided by the Plan. If the marketing involves financial remuneration to the Plan from a third party, your authorization must state that such remuneration is involved.
- **Sale.** We must obtain your authorization for the sale of your protected health information.

Other Uses of Health Information

Other uses and disclosures of health information not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you provide us authorization to use or disclose your health information, you may revoke that authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made under the authorization.

Genetic Information

We may not use or disclose your genetic information for underwriting purposes.

Your Rights Regarding Your Health Information

You have the following rights regarding health information we maintain about you:

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the health information we use or disclose about you for payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care.

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.

To request restrictions, you must make your request in writing to Kerry Brunner, Vice President, Benefits at Ascension. 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 Request Confidential Communications.** You have the right to request that we communicate with you or your responsible party about health matters in an alternative way or at a certain location.

To request confidential communications, you must make your request in writing to Kerry Brunner, Vice President, Benefits at Ascension. You must include the reason for the request, and we will accommodate your request if the disclosure of information could endanger you. Your request must specify how or where you wish to be contacted.

- **Right to Inspect and Copy.** You have the right to inspect and copy information regarding enrollment, payment, claims adjudication and case or medical management record systems maintained by us.

To inspect and copy this information, you can submit your request in writing to Kerry Brunner, Vice President, Benefits at Ascension. 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.

- **Right to Amend.** You have the right to ask us to amend your health and/or billing information for as long as the information is kept by the Plan.

To request an amendment, your request must be made in writing and submitted to Kerry Brunner, Vice President, Benefits at Ascension. In addition, you must provide a reason that supports your request.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- Was not created by us, unless the person or entity that created the information is no longer available to make the amendment.
 - Is not part of the health information kept by or for the Plan.
 - Is not part of the information that you would be permitted to inspect and copy.
 - Is accurate and complete.
- **Right to an Accounting of Disclosures.** You have the right to request a list of certain disclosures that we have made of your health information.

To request this list of disclosures, you must submit your request in writing to Kerry Brunner, Vice President, Benefits at Ascension. Your request must state a time period that may not be longer than six years prior to the date of your request. Your request should indicate in what form you want the list (for example, on paper, electronically). The first list you request within a 12-month period will be free. For additional lists, we may charge you for the cost of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
 - **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. Even if you have agreed to receive this Notice electronically, you are still entitled to a paper copy of this Notice.

Who This Notice Applies To

This Notice describes the Plan's practices and those of all employees, staff, other Plan personnel and the administrators contracted by the Plan to perform administrative services.

Changes to This Notice

We reserve the right to change this Notice. We reserve the right to make the revised Notice effective for health information we already have about you as well as any information we receive in the future. The Notice will contain on the first page, in the top right-hand corner, the effective date. In addition, if we revise the Notice, and you are still a Participant of the Plan, then you may receive a copy of the Notice currently in effect upon request.

Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, contact the person named below. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

If you have any questions about this Notice, please contact:

Kerry Brunner
Vice President, Benefits
Ascension
4600 Edmundson Road
St. Louis, MO 63134

Section 11: Continuation of Coverage

If a Participant terminates employment and is covered by a severance agreement, the Participant may continue to participate in the Plan (or have coverage reinstated and continue to participate) until the termination of the severance agreement. In such event, unless the Participant's severance agreement provides otherwise, the Participant's COBRA continuation coverage that is to be provided in accordance with the rules discussed below will run concurrently with continuing coverage provided under the severance agreement.

If a Participant terminates employment and is eligible for retiree or other post-termination coverage under the provisions of the applicable Addendum, he or she may continue to participate in the Plan (or have coverage reinstated) as provided in the Addendum. In such event, unless the Addendum provides otherwise, the Participant's COBRA continuation coverage will run concurrently with continuing coverage provided under the Addendum.

This section explains your option of continuing medical coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). It also explains how, if you are called to serve in the United States uniformed services, your benefits under this Plan may be protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

COBRA Continuation Coverage

Under COBRA, if you are an Eligible Associate enrolled in the Plan, you and your Eligible Dependents have the option of continuing medical coverage for up to 18 months at full cost if you would otherwise lose coverage because of any of the following events:

- You no longer are employed by your Participating Employer (whether you leave employment voluntarily or involuntarily), except if terminated for gross misconduct).
- Your work hours are reduced below the minimum level necessary to be eligible for this Plan.
- You move to a position with your Participating Employer in which you are not eligible to participate in this Plan.

While termination of employment normally triggers a right to only 18 months of continuation coverage, if your employment terminates less than 18 months after you become entitled to Medicare, the continuation coverage for your Eligible Dependents who are Qualified Beneficiaries can continue for 36 months after the date on which you become entitled to Medicare.

You, your covered Eligible Dependents and a Legally Domiciled Beneficiary will each have an independent right to elect continuation coverage. A Legally Domiciled Beneficiary will be treated as a Qualified Beneficiary eligible for COBRA continuation coverage if the Legally Domiciled Beneficiary will lose coverage because of any of the qualifying events set forth in the Plan. Covered Eligible Dependents who are Qualified Beneficiaries can continue to be covered under the Plan for up to 36 months if they would otherwise lose coverage due to any of the following events:

- The Eligible Associate dies.
- The Eligible Associate and the Eligible Associate's Spouse divorce or become legally separated.
- Medicare becomes the Eligible Associate's Primary coverage.

- An Eligible Dependent Child no longer satisfies the Plan’s definition of Eligible Dependent (for example, the Child reaches the Eligible Dependent age limit).
- If Ascension (or certain related entities) divests your Participating Employer via a certain type of transaction called a “membership substitution” (or a similar transaction in which your employment is not automatically terminated as a result of the divestiture) you and your covered Eligible Dependents will have the same COBRA rights you would have if your employment were to be terminated, regardless of whether your employment is actually terminated in connection with the transaction.

Extended Coverage for Disabled Individuals

A Participant who is disabled on the date of eligibility for continuation coverage or who becomes disabled within the first 60 days of the continuation coverage period may be able to extend coverage for the Participant and other covered family members for up to an additional 11 months (to a total of 29 months).

To qualify, the Social Security Administration must officially determine that the person became disabled prior to the 61st day of the continuation coverage period. Also, that person must notify the Participating Employer in writing of this disability determination before the first 18 months of continuation coverage ends and within 60 days after receiving notification from Social Security that the disability determination has been made. You must send this notice to the Participating Employer (see *Your Contact Information* at the beginning of this SPD).

If the disability ends during the 11 months of extended coverage, the Participant must notify the Participating Employer within 30 days. Continuation coverage will end on the last day of the month in which the disability ended.

Cost

If you choose continuation coverage, you must pay for the coverage. You can be charged up to 102% of the full cost of coverage. Disabled Qualified Beneficiaries and their family members who choose to continue coverage beyond their initial 18-month continuation period can be charged up to 150% of the full cost of coverage during the 11-month disability extension. Contributions must be paid from the date coverage otherwise would have ended.

Second Qualifying Event

If a Qualified Beneficiary other than an Eligible Associate elects continuation coverage and you experience a second qualifying event within the initial 18-month period, you may be able to extend coverage further, but only up to a total of 36 months. The second qualifying event must occur while you have continuation coverage.

You must send a written notice of the second qualifying event to the Participating Employer (see *Your Contact Information* at the beginning of this SPD).

Example: Second Qualifying Event

The family of an Eligible Associate who is laid off becomes eligible for 18 months of continuation coverage. They elect the coverage and then, 7 months later, the Associate dies. The surviving covered dependents are entitled to 36 months of continuation coverage from the date of the Eligible Associate’s termination of employment (the initial qualifying event).

Notification

You must notify the Participating Employer within 60 days after a divorce or legal separation occurs or within 60 days after a covered Eligible Dependent Child loses eligible status. This notice must be sent to the Participating Employer (see *Your Contact Information* at the beginning of this SPD). Failure to provide this notice within the required timeframe will result in a loss of COBRA continuation coverage rights.

Once the Participating Employer receives the notice, the Participating Employer will send a continuation of coverage notice to the individuals who have lost eligibility status along with a continuation of coverage form. They must elect continuation coverage within 60 days after the later of the date Plan coverage ceases or the date of the notice of COBRA continuation rights.

Termination of Coverage

Continuation coverage will end before the maximum COBRA continuation coverage period if one of these events occurs:

- You fail to make contributions on time.
- You become enrolled in Medicare Part A or Part B after you have elected COBRA continuation coverage.
- Your Participating Employer and all related entities that are considered “controlled group” members stop providing a group medical plan for employees.
- You become covered under another group health program after you have elected COBRA continuation coverage.
- You cease to be disabled during the 11-month disability extension period.
- The Plan Administrator terminates your coverage for Cause.

Qualified Beneficiaries are subject to the same rights and rules as those who participate in the Plan.

If you become covered under another group health plan, your continuation coverage would not have to terminate early if your new plan excludes or limits coverage of preexisting conditions. Under those circumstances you could continue to receive the full benefits of your continuation coverage (not only benefits for preexisting conditions) until your original eligibility period of 18, 29 or 36 months ends or until the preexisting conditions limitation or exclusion ends, whichever occurs first.

If you have questions concerning your continuation coverage rights, you should contact the COBRA service provider (see *Contact Information* at the beginning of this SPD). In order to protect your family’s COBRA rights, you should keep your Participating Employer and the Plan Administrator informed of any changes in the addresses of your family members. You should also keep a copy of any notices you send to the Plan Administrator or your Participating Employer.

USERRA Continuation Coverage

If you are an Eligible Associate and take a leave of absence to serve in the United States uniformed services, your benefits under this Plan may be protected by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). You may qualify to choose to continue coverage under the Plan for up to 24 months from the date your leave of absence begins.

USERRA was signed into law in order to ensure that, under certain conditions, those who serve their country can retain their civilian employment and benefits. The continuation coverage mandated under USERRA is separate coverage from that provided under COBRA, although the coverage periods may begin at the same time. However, COBRA coverage can continue for up to 18 months, while USERRA coverage can continue for:

- Up to 24 months from the date the leave commences, or
- The period from the date the leave begins to the day after you fail to return to employment within the time allowed following discharge (for leaves less than 31 days, 1 day is allowed; for leaves 31-180 days, 14 days are allowed; for leaves longer than 180 days, 90 days are allowed).

In addition, COBRA coverage may be terminated for reasons that do not apply to USERRA coverage. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate coverage under USERRA continuation coverage.

If your period of uniformed service is less than 31 days, you are not required to pay more for USERRA coverage than the amount you pay for Plan coverage as an active Eligible Associate. For longer periods, your cost for USERRA coverage will be the same as for COBRA continuation coverage – 102% of the full cost of coverage.

If you were ever on a leave of absence due to military service or are thinking about leaving employment to serve in the military, please contact Ascension HR Central to learn more about your rights under USERRA.

Section 12: Special Situations

Qualified Medical Child Support Orders

The Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Child Support Order (as defined in Section 609(a) of ERISA) as soon as administratively feasible after the Plan Administrator determines that the medical child support order is a Qualified Medical Child Support Order, as described below.

Definitions

For purposes of this section, the following terms will have the meanings given them below:

- “Alternate recipient” means any child of a Participant who is recognized under a medical child support order as having a right to participate in the Plan.
- “Medical child support order” means a judgment, decree or order issued by a court of competent jurisdiction, including approval of a settlement agreement, which is either made pursuant to a state domestic relations law and provides for child support and/or health benefit coverage for a child of a Participant, or which enforces a law relating to medical child support described in section 1908 of the Social Security Act, as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993, (Medicaid) with respect to the Plan.
- “Qualified medical child support order (QMCSO)” means a medical child support order which creates, recognizes or assigns to an alternate recipient the right to receive medical benefits for which a Participant is eligible under the Plan. In order to be qualified, the order must:
- Clearly specify the name and address of the Participant and each alternate recipient covered by the order and reasonably describe the type of coverage to be provided or the manner in which such coverage can be determined;
- Specify the period to which the order applies and the plans which are subject to the order; and
- Not require that the Plan provide any type or form of benefit or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a law relating to medical child support described in section 1908 of the Social Security Act (Medicaid).

Procedures

The Plan Administrator will utilize the following procedures to verify whether any judgment, decree or order is a QMCSO and to administer the provision of benefits under any such order, subject to such changes as are consistent with applicable law and regulations.

- Upon receiving a medical child support order, the Plan Administrator will promptly notify the Participant and the alternate recipient of the receipt of the order and the Plan's procedures for determining whether the order is a QMCSO.
- Within a reasonable period thereafter, the Plan Administrator will determine whether the order satisfies the requirements for a QMCSO and notify the parties of its decision.
- The alternate recipient will be permitted to designate a representative for the receipt of copies of notices that are sent to the alternate recipient.

Status of Alternate Recipients

For all purposes under ERISA, an alternate recipient will be treated as a beneficiary under the Plan. For purposes of the reporting and disclosure rules, an alternate recipient will be treated as a Participant.

Coordination of Benefits Provision

This Plan has a Coordination of Benefits Provision. Benefits under this Plan will be coordinated with:

- Another group health plan that provides medical coverage to an Eligible Associate and/or the Eligible Associate's Eligible Dependents, such as insurance provided by a Spouse's employer.
- Motor vehicle accident insurance.
- Money a Participant could receive from another person or entity who caused the injuries on account of which a claim was made.

When the Plan coordinates benefits, one source of benefits will be "Primary" and the other source will be "Secondary."

- If this Plan is Primary, we will pay benefits as if this Plan is your only source of benefits.
- But if the Plan is Secondary, it will pay the difference between the amount allowed by the Primary source of benefits and the amount that should be paid by the Primary source of benefits. (The amount payable by the other source will be subtracted from the amount allowed by the other source even if the Participant does not apply for benefits from that other source.) The Plan, however, will not pay more than the amount allowed under the Primary source of benefits nor will the Plan pay more than it would have if it were the only source of benefits.

Coordination with Other Group Health Plans

If you incur an expense that would be paid by two or more group health plans, the group health plan with the highest priority is Primary and will pay first. The other group health plan is Secondary and will pay next. Benefits will be paid as follows unless noted otherwise:

- **First:** A group health plan without a coordination of benefits provision will pay.
- **Second:** Then a group health plan covering the patient as an employee, rather than as a dependent, will pay.
- **Third:** Then in the case of a group health plan covering a patient who is a dependent and a minor Child of divorced or legally separated parents:
 - If a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's group health plan (that also covers the Child) will pay;
 - Then a group health plan that covers the Child as a dependent of a custodial parent will pay;
 - Then a group health plan that covers the Child as a dependent of the spouse of the custodial parent will pay;
 - Then a group health plan that covers the Child as a dependent of the non-custodial parent will pay.
- **Fourth:** Then in the case of a group health plan covering a patient who is a dependent and minor Child of married parents, the group health plan of the parent whose birthday occurs earlier in the year will pay.

- **Fifth:** Then in the case of a group health plan covering a patient who is a dependent and minor Child of married parents, the group health plan of the parent whose birthday occurs later in the year will pay.
- **Sixth:** Then the group health plan that has covered the patient for the longer period of time will pay.
- **Seventh:** Then any other group health plan will pay.

If two or more group health plans have the same priority, they will each pay pro-rata.

Note: These special rules apply instead of the priorities listed above.

- COBRA coverage is always Secondary to any other group health plan.
- Coverage provided by virtue of being a retired or laid off employee or an employee on a leave of absence is always Secondary to coverage provided by virtue of that individual being an active employee, except that coverage provided by TRICARE (through the U.S. armed services) is always Secondary to any other employer-sponsored group health plan.

Coordination with Motor Vehicle Accident Insurance

The Plan coordinates payment of its self-funded healthcare benefits on a Secondary basis. Any state insurance law that purports to require the Plan to pay Primary or that does not allow the Plan to subrogate or recover its payments is preempted by ERISA.

This means that even if you are covered under a motor vehicle insurance policy that says other health coverage is Primary, the Plan will still pay Secondary.

You are considered covered under a motor vehicle insurance policy if you are:

- An owner or principal named insured under the policy.
- A family member of a person insured under the policy.
- A person who would be eligible for medical expense benefits under a motor vehicle insurance policy if this Plan did not exist.

If you do not have motor vehicle insurance coverage even though legally required to do so, the Plan will not pay more benefits than it would have paid if you had purchased standard motor vehicle insurance coverage.

However, if you do not have motor vehicle insurance coverage and are a passenger in a vehicle, and the driver also does not have motor vehicle insurance coverage, this Plan will pay Primary.

If you make a claim that may be covered by the Plan provisions governing coordination with motor vehicle insurance as described above, the Plan may initially pay such claim (subject to all other applicable provisions of this Plan) as if the Plan is Primary. If this happens and it is later determined that the Plan provisions governing coordination with motor vehicle insurance apply, the Plan may recover any payments that it would not have made had the Plan not paid the claim initially.

Coordination with Medicare

The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary.

If your Plan coverage is due to current employment status, and you (or the Eligible Associate's Spouse) are over 65 years old and eligible for Medicare, you may reject coverage in this Plan and rely on Medicare as the sole source of coverage. If you do not reject coverage under this Plan, you will have coverage in both this Plan and Medicare, and Medicare will be Secondary.

If your Plan coverage is not due to current employment status, and you (or the Eligible Associate's Spouse) are over 65 years old and also eligible for Medicare, Medicare will be Primary and the Plan will pay only for the reimbursement of Medicare deductibles and coinsurance.

When Medicare is available for certain people who have not yet reached the age of 65, the Plan will be Primary as long your coverage is due to current employment status; otherwise, the Plan will be Secondary.

The Plan will be Primary to Medicare if you qualify for Medicare benefits because of end-stage renal disease for the coordination period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be Secondary to Medicare and only pay Medicare deductibles and coinsurance.

If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if you were enrolled in Medicare, regardless of whether you have applied.

Facility of Payment

If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of these coordination provisions. The Plan will then have no further liability for those expenses or benefits.

Payments by Other Sources

The Plan will not pay any expense or benefit that has actually been paid by another source, even if that other source is Secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Facility of Payment provision (see above) of this Plan applies.

Coordination with Right of Recovery

If Right of Recovery applies (as described in *Section 13*), the Plan is Secondary to a Third Party's liability to an Interested Party.

Limit on Payment When Benefits are Coordinated

Under no circumstances will the Plan pay more than it would have paid had the Plan been the only source of benefits.

Health Benefits Subsidy

The Health Benefits Subsidy is a discount on or waiver of the Participant contribution and certain Deductibles, Copays and Cost-Shares. It is intended to assist Associates who may not have affordable access to healthcare. If a Participant has qualified for a Health Benefits Subsidy, the Participant's contributions will be waived completely or reduced. The waiver or reduction in Participant contributions will be based on factors determined by the Plan Administrator in its sole discretion. Below are some details about the Health Benefits Subsidy.

Note: See the *Plan Outline* at the beginning of this SPD to determine if your Health Ministry offers the Health Benefits Subsidy.

Eligibility

In order to be eligible for the Health Benefits Subsidy:

- Associates must be in a regular, benefit-eligible, full-time or part-time associate status.
- Students, interns, or contracted associates residing internationally will not be covered by the Health Benefits Subsidy.
- If you participate in a collective bargaining agreement, review your contract for eligibility.
- Associates with an Ascension base salary greater than the family income amount for their family size relative to the federal poverty level will not be eligible for the Health Benefits Subsidy.

Components

The Health Benefits Subsidy consists of two components:

- Percentage reduction of Participant Contributions based on family income and family size relative to the federal poverty level, and
- Reduction of out-of-pocket expenses for services incurred in the Ascension Network.

Reduction of Associate Contributions

The reduction of Participant Contributions toward the Plan will be based on the following discount schedule:

- Total household income of less than 100% of the federal poverty level for that family size will receive a 100% discount in Participant Contributions toward the Plan.
- Total household income of less than 150% of the federal poverty level for that family size will receive a 75% discount in Participant Contributions toward the Plan.
- Total household income of less than 200% of the federal poverty level for that family size will receive a 50% discount in Participant Contributions toward the Plan.
- Total household income of less than 250% of the federal poverty level for that family size will receive a 25% discount in Participant Contributions toward the Plan.

Waiver of Ascension Network Charges

Associates who qualify for a 25% or 50% reduction of Cost-Sharing will qualify for a 50% reduction of Ascension Network out-of-pocket expenses, including Deductibles, Cost-Shares and out-of-pocket maximums.

Associates who qualify for a 75% or 100% reduction of Cost-Sharing will qualify for a 100% reduction of Ascension Network out-of-pocket expenses, including Deductibles, Cost-Shares and out-of-pocket maximums.

When to Apply

An Eligible Associate may qualify for the Health Benefits Subsidy at any time. For more information and to apply for the Health Benefits Subsidy, go online to the [Socially Just Benefits Administration](#) page.

Section 13: Other Plan Provisions

Right of Recovery

If a Participant sustains an Illness or Injury for which benefits are payable under the terms of the Plan, and a Third Party is or may be liable with respect to such Illness or Injury, the Plan shall have the right of recovery (the “Right of Recovery”). The Plan shall have the Right of Recovery with respect to any recovery, right of recovery, claim, cause of action or other rights that any or all Interested Parties may have against a Third Party.

The term “Third party” means any entity or person, including but not limited to, an insurance company (for example, the Participant’s own insurance company, in the case of uninsured or underinsured motorist coverage or no-fault automobile insurance). The term “Interested Party” means any person or entity who has or may have a right of recovery, claim, cause of action or other right arising out of or related to the Illness or Injury (or any loss related thereto) sustained by the Participant; such term shall include, but shall in no way be limited to, the Participant’s estate (or personal representative of the estate), heirs, guardian or other representative.

By accepting benefits from the Plan (whether the Plan makes payment to the Participant or on behalf of the Participant) for an Illness or Injury, a Participant agrees that if the Participant also receives any payment from any Third Party as a result of the Illness or Injury the Participant will serve as a constructive trustee over the funds. This means that the Participant must hold these funds in trust for the Plan, and failure to hold the funds for the Plan will be deemed a breach of the Participant’s fiduciary duty to the Plan.

The Plan will automatically have an equitable lien to the extent of benefits paid by the Plan for the treatment of an Illness or Injury for which a Third Party is liable. The lien will be imposed upon any recovery (whether by settlement, judgment, or otherwise) from a Third Party related to treatment for any Illness or Injury 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, the Participant; the Participant’s representative or agent; a party that is actually, possibly, or potentially responsible for making any payment in connection with the Illness or Injury; such responsible party’s insurer, representative, or agent; and/or any other source possessing funds representing the amount of benefits paid by the Plan.

The Right of Recovery includes:

- The right to recover from any Interested Party all amounts the Interested Party may recover or receive from any Third Party with respect to the Illness or Injury for which benefits are payable under the terms of the Plan;
- The right to reduce the amount of covered Plan benefits payable with respect to the Illness or Injury, by any amount or amounts recovered by an Interested Party from a Third Party with respect to or as a result of the same Illness or Injury; and
- The right of subrogation to stand in the shoes of an Interested Party and assert any right of recovery, claim or cause of action that the Interested Party may have against a Third Party arising from or related to the Illness or Injury for which benefits are payable under the terms of the Plan; the Plan’s right of subrogation includes the right to control absolutely the prosecution

of the subrogated right of recovery, claim or cause of action, including, but not limited to, the selection of counsel.

The Plan's Right of Recovery shall be determined as follows:

- The Plan shall have a first priority lien on any full or partial recovery by an Interested Party from a Third Party. The Plan's Right of Recovery shall apply regardless of whether or not the Interested Party is made whole from the recovery against such Third Party. Any recovery amount that the Plan is entitled to shall not be reduced or prorated by or on account of the Interested Party's attorney's fees and costs.
- Any full or partial recovery by an Interested Party against a Third Party shall be deemed to be recovery for Plan benefits with respect to the Illness or Injury for which the Third Party is or may be liable, regardless of whether or not the judgment, award, formal or informal settlement, contract or any other payment of any kind itemizes or identifies an amount awarded for Plan benefits or is specifically limited to certain kinds of damages or payments; an Interested Party may not avoid or circumvent the Plan's Right of Recovery because of the way in which the recovery from a Third Party is characterized. By way of example, the Plan shall have a Right of Recovery even if an Interested Party's recovery from a Third Party is described as a recovery for pain and suffering, loss of consortium, emotional distress, punitive damages, damages for vexatious refusal to pay, attorneys' fees, or medical expenses.
- The Plan Administrator, in its sole and absolute discretion, may agree to treat a lesser percentage of an Interested Party's recovery from a Third Party as attributable to Plan benefits. The amount so determined shall be binding on the Plan and the Interested Party as the amount of Plan benefits to which the Plan has the Right of Recovery.

If the Plan has a Right of Recovery, the Plan shall not be obligated to pay any Plan benefits with respect to the Participant's Illness or Injury until all of the following conditions are fulfilled to the complete satisfaction of the Plan Administrator in its sole and absolute discretion, and payment of such Plan benefits is subject to the fulfillment of such conditions.

- If the Plan Administrator desires to assert the Plan's right of subrogation, all Interested Parties (or someone legally qualified and authorized to act for an Interested Party) must sign all documents required by the Plan Administrator to assert such right.
- If the Plan Administrator, in its sole and absolute discretion, decides not to assert the Plan's right of subrogation, the following conditions shall apply:
 - The Interested Party shall include the Plan benefits in any claim or cause of action the Interested Party makes against a Third Party for the Illness or Injury (or any loss related thereto);
 - The Interested Party shall acknowledge and agree that the Plan has an absolute Right of Recovery and a first priority lien in any recovery made by the Interested Party related to the Illness or Injury for which Plan benefits have or will be paid;
 - The Interested Party shall not settle a claim against a Third Party without prior written consent of the Plan Administrator; and
 - All Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to the foregoing conditions upon request by the Plan Administrator.

- All Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to cooperate fully with the Plan in asserting and protecting its Right of Recovery, supply the Plan Administrator with any and all information necessary to assert and protect such Right of Recovery, and execute and deliver any and all instruments and papers in their original form, as described immediately below in the paragraphs that describes the obligation to cooperate with the Plan's efforts to recover benefits paid.

Cooperation with the Plan's efforts to recover benefits paid:

- All Interested Parties (and each person who is legally qualified and authorized to act for an Interested Party) shall fully cooperate with the Plan's efforts to recover its benefits paid. All Interested Parties (and each person who is legally qualified and authorized to act for an Interested Party) shall provide all information requested by the Plan, the Plan Administrator, the Claims Administrator, or their representatives including without limitation, completing and submitting any applications or other forms or statements as any such party may reasonably request. Failure to provide this information may result in the termination of Plan coverage for the Participant or a lawsuit filed against the Participant.
- All Interested Parties (and each person who is legally qualified and authorized to act for an Interested Party) shall refrain from doing anything to prejudice the Plan's subrogation or recovery interest or to prejudice the Plan's ability to enforce the terms of these Right of Recovery provisions. 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.
- All Interested Parties (and each person who is legally qualified and authorized to act for an Interested Party) acknowledge and agree that the Plan has the right to conduct an investigation regarding the Illness or Injury to identify any responsible party. The Plan reserves the right to notify any responsible party and the responsible party's agents of its lien. Agents include, but are not limited to, insurance companies and attorneys.

The Plan Administrator, in its sole and absolute discretion, may suspend payment of Plan benefits if any Interested Party has not executed or is not in compliance with the terms of any required written agreement or is in violation of the terms of or has failed to satisfy any condition of this *Right of Recovery* subsection. Payment of benefits pursuant to the Plan before any required written agreement is obtained, or while an Interested Party is not in compliance with the terms of such a written agreement, or while an Interested Party is in violation of the terms of or has failed to satisfy any condition of this *Right of Recovery* subsection, shall not constitute a waiver by the Plan of its Right of Recovery. Violation of any required written agreement shall be a violation of the terms of the Plan document.

The Plan Administrator, in its sole and absolute discretion, may agree to waive the Plan's Right of Recovery. The Plan's waiver of its Right of Recovery with respect to one claim shall not constitute a waiver of its Right of Recovery with respect to another claim; and the Plan's waiver of its Right of Recovery with respect to one Interested Party shall not constitute a waiver of its Right of Recovery with respect to another Interested Party.

An Interested Party shall notify the Plan Administrator, in writing, whenever an Illness or Injury arises that provides or may provide the Plan a Right of Recovery. The Plan shall be entitled to recover its attorney's fees and costs from an Interested Party if the Plan takes legal action against or otherwise participates in any legal or administrative proceeding concerning the Interested Party to enforce its reimbursement rights.

Overpayment of Claims

An overpayment occurs if:

- The Plan pays for services not eligible under the Plan.
- The Plan pays an expense or benefit more than once.
- An expense or benefit is paid by both the Plan and a third party.

If an overpayment is made by the Plan to the Participant or a third party (such as a healthcare provider), the Plan has the right to recover the overpayment made. If the overpayment is made to a healthcare provider, the Plan may request a refund of the overpayment from either the Participant or the provider.

If the refund is not received, the overpayment may be deducted from future Plan benefits available to the Participant or Eligible Dependents or from the Participant's wages, but the amounts withheld may not reduce the wages below the applicable state minimum wage law to the extent permitted by law.

Any overpayment an Associate owes due to a dependent's ineligibility under the Plan will be offset by the amount of any contributions paid for dependent coverage while the dependent was ineligible.

Right to Amend or Discontinue the Plan

Ascension and your Participating Employer are committed to maintaining the Plan. However, Ascension, the Plan Sponsor, reserves the right to amend or terminate the Plan in whole or in part, at any time, and for any reason, without advance notice. Amendment or termination of the Plan shall be effective if it is approved in writing by a duly authorized officer of Ascension, or if it is adopted pursuant to Ascension's procedures allocating or delegating authority to act on behalf of Ascension, as such procedures exist from time to time.

Any Participating Employer will be permitted to discontinue or revoke its participation in the Plan. Coverage under this Plan will automatically terminate with respect to all Participants of a Participating Employer as of the date the Health Ministry ceases to be a Participating Employer.

Construction of Plan

This Plan shall be construed and enforced according to ERISA and the laws of the State of Missouri to the extent not preempted by ERISA.

Forum Selection Clause

The Plan contains a forum selection clause, which requires that any lawsuit relating to or arising under the Plan shall be brought and resolved only in the United States District Court for the Eastern District of Missouri, and in any courts in which appeals from such court are heard, and such court shall have personal jurisdiction over any Participant or Eligible Dependent named in such action.

Section 14: Plan Information

Official Plan Name	Ascension SmartHealth Medical Plan
Employer Identification Number	45-3358926
Plan Number	514
Type of Plan Benefits	Group health plan
Plan Sponsor and Administrator	Ascension Health Alliance d/b/a Ascension 4600 Edmundson Road St. Louis, MO 63134 314-733-8000
Type of Administration	The Plan is administered by Ascension (or a person or third party that Ascension may appoint to administer the Plan).
Plan Year	Plan records are administered on a calendar-year basis beginning January 1 and ending December 31 of each year.
Agent for Service of Legal Process	Ascension Health Alliance d/b/a Ascension 4600 Edmundson Road St. Louis, MO 63134 314-733-8000
Type of Funding	You and your Participating Employer share the cost of this benefit coverage. Benefits are not insured and are paid out of the general assets of the Participating Employer.

Appendix I: Glossary

You may find it helpful to refer to this glossary for definitions of specific terms that are used in this SPD.

Accredited Care Facility

- For Substance Use Disorder services, a facility licensed, certified, or approved as a treatment facility by the state or jurisdiction in which it operates, operating primarily for treatment of Substance Use Disorder conditions which maintains permanent and full-time facilities for bed care and full-time confinement of at least 15 patients; has a Physician in regular attendance; provides 24 hour per day nursing by a registered nurse; and has a full-time psychiatrist or psychologist on the staff.
- For Psychiatric Treatment, a facility-licensed, certified, or approved as a Psychiatric Treatment facility by the state or jurisdiction in which it is located, and which primarily provides psychiatric services for the diagnosis and treatment of mentally ill persons, by or under the supervision of a Physician.

Addendum

A written supplement in Appendix B of the Plan document, setting forth the specific provisions of the Plan elected by a Participating Employer. Notwithstanding any provision of the Plan to the contrary, if the terms of an Addendum and terms of the Plan conflict, the terms of the Addendum shall control.

Note: The *Plan Outline and Schedule(s) of Benefits* at the beginning of this SPD is based on this written supplement.

Allowable Amounts

Amounts that Network providers have agreed to accept from the Plan for Covered Expenses.

Ambulatory Care Center

Any public or private state licensed and approved (wherever required by law) establishment with an organized medical staff of physicians, with permanent facilities that are equipped and operated primarily for the purpose of performing surgical procedures, with continuous physician services and registered professional nursing service whenever a patient is in the facility, and which does not provide service or other accommodations for patients to stay overnight.

Annual Out-of-Pocket Maximum

The maximum amount of Covered Expenses required to be paid by a Participant in a Plan Year including Deductibles, Copays and similar charges.

Associate

Any individual who is classified by a Participating Employer as an employee of the Participating Employer (regardless of retroactive reclassification for any purpose), while such individual is so classified.

Balance Billing

An Out-of-Network provider billing a Participant for the difference between the charges billed by such provider and Covered Expenses. Balance Billing amounts do not count toward your Copays, Deductibles, and Cost-Share or Annual Out-of-Pocket Maximum.

Benefit Elevation

Payment of Covered Expenses at a higher Tier than would otherwise apply if certain conditions are satisfied.

Benefit Elevation Approval

Approval of a Benefit Elevation request by the Plan Administrator or its delegate. Such approval will be granted to a Participant only if the Participant seeks approval for the Benefit Elevation in advance of or within 180 days after the treatment or service for which Benefit Elevation is requested. Benefit Elevation Approval is independent of any applicable Prior Authorization requirements under the Plan.

Birthing Center

A facility operated by a Hospital or other licensed health care institution for the purposes of providing facilities for childbirth as an alternative to the environment of the Hospital delivery room.

Board of Trustees

The Board of Trustees of the Sponsor or any committee authorized by such Board to act on its behalf with respect to the Plan.

Cause

The Participant's failure to complete, sign and/or provide to the Plan Administrator any information, document or form that Ascension determines is reasonably necessary for Plan administration or Plan settlor functions, the Participant's willful engagement in misconduct that is materially injurious to the Plan, dishonesty by the Participant in connection with the provision of benefits under the Plan, fraudulent or unethical conduct or an intentional misrepresentation of a material fact by the Participant related to or affecting the provision of benefits under the Plan, or the Participant's failure to pay any amounts due and owing to the Plan or a Participating Employer.

Change Event

A change in status or change in family status event that is described in the Code Section 125 cafeteria plan adopted by the Participating Employer of the Eligible Associate.

Change of Benefits Date

The effective date of a mid-year election change due to a Change Event. The Change of Benefits Date for a Change Event related to birth, adoption or placement for adoption shall be the date of the birth, adoption or placement for adoption. The Change of Benefits Date for all other Change Events shall be as soon as administratively possible after the requested change is filed, as prescribed by the Plan Administrator, or as otherwise specified in the Addendum applicable to the Associate's Participating Employer.

Child

Child means:

- The Eligible Associate's natural child;
- The Eligible Associate's legally adopted child;
- A child placed with the Eligible Associate for adoption;
- A foster child of the Eligible Associate;

- The Eligible Associate's stepchild; or
- Any child with respect to whom the Eligible Associate has been granted full legal (both managing and possessory conservatory) custody or guardianship.

Claims Administrator

The entity or individual that is responsible for determining a claim. This reference applies to the Plan Administrator or a third party hired by the Plan Administrator to determine claims.

COBRA

The continuation of health coverage that must be offered in accordance with the Consolidated Omnibus Budget Reconciliation Act of 1985, along with amendments to such law and any pertinent Treasury regulations, rulings, notices or other promulgations

Code

The Internal Revenue Code of 1986, as amended. Reference to a section of the Code shall include that section and any comparable section or sections of any future legislation that amends, supplements or supersedes said section, and all regulations promulgated thereunder.

Copay

A service-specific, fixed-dollar amount that you pay at the time and place services are rendered.

Cosmetic Surgery

Reconstructive or plastic surgery which is done primarily to improve the physical appearance of the patient and which improves the physical appearance but does not correct or improve a medical condition.

Cost-Share/Cost-Shares/Cost-Sharing

The amount owed by the Participant after payment, if any, by the Plan, whether through Copays, Deductibles and/or Balance Billing amounts.

Covered Drug

Those prescription drugs, supplies and other items covered under this Plan.

Covered Expenses

Costs incurred with respect to Medically Necessary covered services, supplies and charges described in *Section 5*. Covered Expenses shall be limited to Allowable Amounts for Network providers and the Maximum Payable Charge for Out-of-Network providers. In addition to meeting applicable requirements of the Plan, in order for a service to constitute a Covered Expense, the service must meet requirements of applicable policies of the Plan's utilization vendor.

Custodial Care

Care or confinement provided primarily for the maintenance of the individual, essentially designed to assist the individual, whether or not totally disabled, in the activities of daily living, which could be rendered at home or by persons without professional skills or training. This care is not reasonably expected to improve the underlying medical condition, even though it may relieve symptoms or pain. Such care includes, but is not limited to, bathing, dressing, feeding and preparation of special diets, assistance in walking or getting in or out of bed, supervision over medication which can normally be self-

administered and all domestic activities. Such care is custodial even if the level of maintenance care requires the services of some skilled health professionals. Custodial Care also includes rest cures, respite care and home care provided by family members.

Deductible

The amount of Covered Expenses that an individual and/or family must satisfy in a Plan Year before being eligible for certain benefits to be payable by the Plan. With respect to family coverage under a High Deductible Health Plan, the family Deductible amount must be satisfied before the Plan will pay any benefits that are subject to a Deductible for any individual participant in the family that is the subject of such family coverage.

Dentist

A person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.

Developmental Delay

Any condition that interrupts or delays the sequence and rate of normal growth, development and maturation.

Disabled Dependent Child

A Child who is 26 years old or older, unmarried, permanently and totally disabled prior to attaining age 26, receiving over one-half of his or her support from the Eligible Associate or the Eligible Associate's Spouse, and eligible to be claimed as a dependent on the Eligible Associate's or Eligible Associate's Spouse's Federal income tax return. A Child is "permanently and totally disabled" and if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve months.

DME

Durable medical equipment which can withstand repeated use; is primarily and customarily used to serve a medical purpose; generally is not useful to a person in the absence of an Illness or Injury; and is appropriate for use in the home.

Eligible Associate

An Associate who is in the class of Associates eligible to participate in the Plan, as specified in the eligibility provisions of the Addendum applicable to the Associate's Participating Employer. Such term may also include a former Associate of the Participating Employer who is in a class of retirees eligible for retiree coverage under the Plan in accordance with the eligibility and participation requirements specified in the Addendum applicable to the Associate's Participating Employer.

Eligible Dependent

An Eligible Associate's:

- Spouse;
- Child who is less than 26 years old; or
- Disabled Dependent Child.

Emergency Room

A hospital room or area staffed and equipped for the reception and treatment of persons with conditions (Illness or Injury) requiring immediate medical treatment.

Entry Date

The date on which an Eligible Associate becomes a Participant in the Plan after completing the enrollment process set forth in the Plan and any waiting period applicable to such Eligible Associate. The Entry Date applicable to an Eligible Associate shall be specified in the Addendum applicable to the Eligible Associate's Participating Employer.

ERISA

The Employee Retirement Income Security Act of 1974, as amended. Reference to a section of ERISA shall include that section and any comparable section or sections of any future legislation that amends, supplements or supersedes said section.

E-visit

A medical treatment or visit which consists only of a telephone conversation, email or internet exchange or other non-face-to-face encounter where you or your medical provider are not physically present in the same room at the same time.

Expenses Incurred

A charge, which shall be deemed to be incurred on the day the purchase is made, or on the day the service is rendered, regardless of when the Participant is actually billed for or pays for the charge. With respect to a course of treatment or procedure that includes several steps or phases of treatment, expenses are incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, expenses for the entire procedure or course of treatment are not incurred upon commencement of the first step of the procedure or course or treatment.

Experimental Treatment

A treatment, device or drug that:

- Is prescribed by a non-licensed provider; or
- Is governed by the FDA and, except in the case of Off-Label Drug Use, has not been approved by the FDA for the particular condition at the time the treatment device, or drug is provided; or
- Except for "Approved Clinical Trials" as the term is defined in Title XXVII of the Public Health Service Act, Section 2709, is provided as part of an ongoing Phase I or II or III clinical trial as defined by the National Institutes of Health, National Cancer Institute or the FDA. In the event that an FDA approved drug or device is used for a particular condition during an ongoing Phase I or II or III clinical trial, and one or more other drugs or devices not FDA approved for such trial are also used, then all FDA approved and FDA non-approved drugs or devices shall be considered Experimental Treatment; or
- Is documented in a major U.S. peer-reviewed medical or scientific journal stating that further research, studies, or clinical trials are necessary to determine the safety, toxicity or efficacy of the treatment, device, or drug; or

- Is any treatment, device, drug or hospital confinement that arises from, relates to or is provided in connection with the Experimental Treatment or drug whether or not the treatment, drug or hospital confinement, on its own, is considered Medically Necessary. The Plan Administrator will determine what is considered Experimental Treatment for the purpose of determining Covered Expenses under this Plan by reviewing the Claims Administrator's evaluation of treatment, device or drug, as well as studies, opinions and references to or by the American Medical Association, FDA, Department of Health and Human Services, National Institutes of Health, Council of Medical Specialty Societies, American Hospital Formulary Services Drug Information, American Academy of Pediatrics and any other association, federal program or agency that has the authority to approve medical testing or treatment.

Extended Care Facility

An institution (or a distinct part of an institution) that:

- Is primarily engaged in providing for Inpatient, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;
- Has policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides;
- Has a Physician, a registered nurse, or a medical staff responsible for the execution of such policies;
- Has a requirement that the health care of every patient must be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency;
- Maintains clinical records on all patients;
- Provides 24-hour nursing care in accordance with the policies developed as provided in the second subparagraph above, and has at least one registered nurse employed full-time;
- Provides appropriate methods and procedures for dispensing and administering drugs and biologicals;
- Has in effect a utilization review plan which provides for the review, on a sample or other basis, of admissions to the institution, the duration of stays, and the professional services (including drugs and biologicals) furnished with respect to the Medical Necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services. Such review shall be made by either a staff committee of the institution composed of two or more Physicians, with or without participation of other professional personnel, or a group similarly composed which is established by the local medical society and some or all of the Hospitals and Extended Care Facilities in the locality. Such review provides for prompt notification to the facility, the individual, and the attending Physician of a finding that further stay in the facility is not Medically Necessary;
- Is licensed pursuant to an applicable state or local law or is approved by the appropriate state or local agency for such licensing, except that such term shall not include any institution which is primarily used for Custodial Care.

FDA

The U.S. Food & Drug Administration.

Health Benefits Subsidy

A discount on or waiver of the Participant Contribution and certain Deductibles, Copays and Cost-Shares designed to assist an Associate who may not have affordable access to healthcare. The Associate must apply for the subsidy at the time specified by the Plan Administrator on an application form acceptable to the Plan Administrator, and be determined by the Plan Administrator to have demonstrated need under guidelines approved by the Plan Administrator.

Note: The Health Benefits Subsidy is only available to eligible Participants who elect the SmartHealth Preferred Provider Organization (“PPO”) Plan option (eligible Participants may not elect the High Deductible Health Plan (“HDHP”) option).

Health Ministry

Any legal entity that is related to the Sponsor.

High Deductible Health Plan

A plan or coverage option under a plan offered by a Participating Employer that qualifies as a high deductible health plan under Code Section 223(c)(2).

High Tech Radiology Procedure

Advanced procedures with a dose of radiation that require Prior Authorization. See imaging list on at <https://mysmarthealth.org/>.

Home Health Agency

An agency or organization that provides a program of home health care and that:

- Is approved as a home health agency under Medicare; or
- Is established and operated in accordance with the applicable laws in the jurisdiction in which it is located and, where licensing is required, has been licensed and approved by the regulatory authority having the responsibility for licensing; or
- Meets all of the following requirements: (i) is an agency which holds itself forth to the public as having the primary purpose of providing a home health care delivery system bringing supportive services to the home; (ii) has a full-time administrator; (iii) maintains written records of services provided to the patient; (iv) staff includes at least one registered nurse or has nursing care by a registered nurse available; and (v) employees are bonded and are provided with malpractice insurance.

Hospice Care Program

A program that has the primary purpose of providing hospice services to hospice patients. It must be licensed and operated according to the laws of the state in which it is located and meet all of the following requirements:

- Has obtained any required certificate of need;
- Provides 24-hour–a-day, seven days-a-week service,

- Supervised by a physician or nurse practitioner,
- Has a full-time coordinator,
- Keeps written records of services provided to each patient,
- Has a nurse coordinator who is a registered nurse with four years of full-time clinical experience of which at least two years involved caring for terminally ill patients, and
- Has a licensed social service coordinator.

A Hospice Care Program will establish policies for the provision of hospice care, assess the patient's medical and social needs and develop a program to meet those needs. It will provide an on-going quality assurance program, permit area medical personnel to use its services for their patients and use volunteers trained in care of and services for non-medical needs.

Hospital

An institution that meets all of the following requirements:

- Provides medical and surgical facilities for the treatment and care of injured or sick persons on an inpatient basis;
- Is under the supervision of a staff of physicians;
- Provides 24-hour-a-day nursing service by registered nurses;
- Is duly licensed as a hospital, except that this requirement will not apply in the case of a state tax-supported institution;
- Is not, other than incidentally, a place for rest, a place for the aged, a nursing home or a custodial or training-type institution; and
- Is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the American Medical Association and the American Hospital Association.

The requirement above that the institution provide surgical facilities does not apply to a hospital specializing in the care and treatment of mentally ill patients, provided such institution is accredited by the Joint Commission on Accreditation of Healthcare Organizations sponsored by the American Medical Association and the American Hospital Association.

Hospital Confinement or Hospital Confined

A person is deemed to be confined in a Hospital, for purposes of this Plan, if the person's confinement continues for more than 23 consecutive hours or longer and if a Room and Board charge is made in connection with such person's confinement; or if the confinement (other than a Hospital Observation Stay) is required because of a Surgical Procedure.

Hospital Observation Stay

A person is deemed to be incurring a Hospital Observation Stay, for purposes of this Plan, if the person's observation confinement involves a well-defined set of specific, clinically appropriate services, which include ongoing short-term treatment, assessment and reassessment, that are furnished while a decision is being made regarding whether patients will require further treatment as hospital inpatients or if they are able to be discharged from the hospital. A person may not remain in observation status for more than 24 or 48 hours.

Illness

A sickness or disease including mental infirmity, as classified in the current edition of the International Statistical Classification of Diseases and Related Health Problems and which requires treatment by a Physician. For purposes of determining benefits payable, "Illness" shall include Pregnancy.

Injury

Bodily injury sustained accidentally by external means, including such Illness as results from an accident.

Inpatient

Treatment of a person who is Hospital Confined.

Legally Domiciled Beneficiary

An individual who shares a primary residence with the Eligible Associate, remains a member of the Eligible Associate's household throughout the coverage period, and either:

- Has shared the basic living expenses and been financially interdependent with the Eligible Associate for at least six consecutive months with the intention of remaining in the relationship indefinitely; is neither legally married to anyone else nor legally related to the Eligible Associate by blood in any way that would prohibit marriage; and is neither receiving benefits from Medicare nor eligible for Medicare; or
- Is the Eligible Associate's blood relative who meets the definition of the Eligible Associate's tax dependent as defined by Code Section 152 during the coverage period and is neither receiving benefits from Medicare nor eligible for Medicare.

A Legally Domiciled Beneficiary does not include an Eligible Dependent or any employee of the Eligible Associate.

Maintenance Medication

A prescription drug that generally requires regular use (for example, daily, weekly, monthly) to treat a condition that is considered chronic or long-term. Examples of Maintenance Medications include those used to treat high blood pressure, heart disease, asthma and diabetes.

Manufacturer Patient Assistance Program

A program that a drug manufacturer offers to the public in which a consumer may reduce the consumer's out-of-pocket costs for prescription drugs by using coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means. The value received from coupons, discount cards, prepaid gift cards, manufacturer debit card or other means do not apply to deductibles or out-of-pocket maximums.

Maximum Payable Charge

With respect to any treatment, service, supply, or other charge provided by an Out-of-Network provider, the Allowable Amount that would have been applicable had the same treatment, service, supply, or other charge been provided by a National Network provider participating in the same area as the Out-of-Network provider. For these purposes, the term "area" means a metropolitan area, county, or such greater area as the Plan Administrator deems necessary or appropriate to establish the Maximum Payable Charge for any given treatment, service, supply, or other charge. All determinations of Maximum Payable Charges will be made by the Plan Administrator.

Medical Emergency

A medical condition which manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Medically Necessary/Medical Necessity

Treatment, service or supply that:

- Is appropriate and essential for the diagnosis or treatment of the Participant's symptoms;
- Is within the scope, duration or intensity of that level of care which is needed to provide safe, adequate and appropriate diagnosis or treatment,
- Is in accordance with generally accepted current professional medical practice, and
- Involves only the use of drugs or substances that are not Experimental Treatment. A treatment, service or supply will not be considered Medically Necessary if it is part of a treatment plan that is Experimental Treatment or conducted for research purposes, or if it is provided primarily as a convenience to the Participant, the Participant's family or the Participant's Physician or other health care provider. The fact that a physician may prescribe, order, recommend or approve a treatment, service or supply does not of itself make the treatment, service or supply Medically Necessary.

In furtherance of the foregoing and without limitation, for acute Inpatient care Medically Necessary shall mean that the care is necessary due to the kind of services the Participant is receiving or the severity of the Participant's medical condition, and that safe and adequate care cannot be received as an Outpatient or in a less-intensive setting.

The decision of the Plan Administrator is not intended to influence or alter the treating provider's medical judgment.

All determinations of what constitutes "Medically Necessary" shall be made in accordance with the policies and procedures established by or at the direction of the Plan Administrator and applied by the Claims Administrator.

Medicare

The programs established by Title 1 of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act, and which includes Part A—Hospital Insurance Benefits for the Aged, and Part B—Supplementary Medical Insurance Benefits for the Aged.

Midwife

A person who is certified by the American Midwifery Certification Board to supervise the conduct of labor and childbirth, advise the parents as to the progress of the childbirth and furnish prenatal, intrapartum and postpartum care.

Network

Those facilities and Physicians that have contracted with (or have been designated by) the Plan Administrator to participate in the Network and that have agreed to accept negotiated Allowable Amounts as payment in full for Covered Expenses. There are two tiers of provider participation:

- Ascension Network, which consists of those facilities that are wholly, or in part, sponsored by a Health Ministry of Ascension. Physicians included in the Ascension Network shall have contracted with the Plan Administrator either individually on their own behalf or through the Health Ministry facility with whom they are affiliated. The Plan Administrator may designate or contract with other facilities and Physicians to be part of the Ascension Network in order to ensure network adequacy.
- National Network, which consists of those facilities or Physicians that are not Ascension Network facilities or providers but have contracted with the National Network utilized by a Health Ministry of Ascension. The National Network may consist of a standard National Network and one or more sub-networks and/or sub-tiers. Unless otherwise indicated in an Addendum, the standard National Network shall apply. If a sub-network or sub-tier applies to a Participating Employer, the terms governing the sub-network or sub-tier will be set forth in the Participating Employer's Addendum.

Prior to January 1, 2015, the Ascension Network was called "Tier 1" and the National Network was called "Tier 2." Although the Plan Administrator is phasing out the prior terms, they may still occasionally appear in Plan-related communications and forms until all Plan-related documents have been updated.

Off-Label Drug Use

The use of a drug that is approved by the Food and Drug Administration for the treatment of one medical condition but is used to treat another medical condition, or at different dosage forms, dosage regimens, populations, or other parameters not mentioned in the approved labeling, as provided in and subject to the requirements and conditions of the applicable policies of the Plan Administrator or the Plan's utilization vendor.

Out-of-Network

Facilities or Physicians who are not Ascension Network or National Network Providers. Prior to January 1, 2015, Out-of-Network was called "Tier 3." Although the Plan Administrator is phasing out the prior term, it may still occasionally appear in Plan-related communications and forms until all Plan-related documents have been updated.

Outpatient

Treatment at a Hospital to a person who is not Hospital Confined; or treatment rendered in a Physician's office, laboratory, x-ray facility, Ambulatory Care Center and/or Emergency Center.

Participant

Any Eligible Associate, Eligible Dependent, COBRA Qualified Beneficiary or other individual who is covered under the Plan in accordance with the provisions of Article 2 of the Plan. See *Section 2* and the *Plan Outline and Schedule(s) of Benefits* for details.

Participant Contribution

Any amount which the Plan Administrator may require a Participant to contribute in accordance with the Plan.

Participating Employer

The Sponsor or any Health Ministry that adopts the Plan in accordance with Section 9.2 of the Plan.

PHSA

The Public Health Service Act of 1944, as amended from time to time.

Physician

A medical practitioner who is licensed and legally qualified to prescribe and administer all drugs and to perform all Surgical Procedures, or a licensed Dentist practicing within the terms of the Dentist's license, or a psychologist practicing in conformity with applicable laws, or any other licensed or certified practitioner of the healing arts in a category specifically favored under the health insurance laws in the state where the license or certification was issued, practicing within the terms of the practitioner's license or certification.

Plan

The Ascension SmartHealth Medical Plan, as amended from time to time.

Plan Administrator

Ascension, or such other person or committee that Ascension may appoint to administer the Plan.

Plan Year

Each twelve-consecutive-month period beginning January 1 and ending December 31.

PPACA

The Patient Protection and Affordable Care Act of 2010, as amended from time to time.

Pregnancy

Carrying a child, resulting childbirth, miscarriage and any complications of childbirth.

Preventive Services Guideline

A document maintained and updated from time to time by the Plan Administrator that sets forth the health care services that are covered as preventive care services, the limitations and conditions on such services, and the codes that are used by healthcare providers to classify and code diagnoses, symptoms and preventive care procedures and services.

Primary

A source of benefits, such as a group health plan, motor vehicle accident insurance, or money from a person or entity who caused injury, which has the initial responsibility to pay expenses incurred for medical care. When the Plan is Primary, it pays benefits for expenses incurred according to the Plan's terms and as if there is no other source of benefits.

Prior Authorization

Prior approval by the Claims Administrator or the Plan's utilization vendor of select services to be performed on a Participant to determine if requested services are Medically Necessary.

Private Duty Nursing

Hourly, skilled nursing care provided in a patient's home. Private Duty Nursing provides more individual and continuous skilled care than can be provided in a skilled nurse visit through a home health agency. The intent of Private Duty Nursing is to assist the patient with complex direct skilled nursing care, to develop caregiver competencies through training and education, and to optimize patient health status and outcomes. Private Duty Nursing is Medically Necessary continuous, substantial and complex hourly nursing services provided by a licensed nurse in the patient's home. The nursing tasks must be done so frequently that the need is continuous.

Psychiatric Treatment

Treatment for any illness or condition, regardless of whether the cause is organic, that is classified as a Mental Disorder in the current edition of International Statistical Classification of Diseases and Related Health Problems, published by the U.S. Department of Health and Human Services, or is listed in the current edition of Diagnostic and Statistical Manual of Mental Disorders, published by the American Psychiatric Association.

Qualified Beneficiary

Any person afforded rights of continued benefits under COBRA as a result of a qualifying event as defined in COBRA.

Qualifying Medical Care Expense

Any expense of the Participant or an Eligible Dependent which would qualify as a "medical care" expense (within the meaning of Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder), provided that Qualifying Medical Care Expense shall not include expenses for "qualified long-term care services" as defined in Code Section 7702B(c) or expenses which the Plan Administrator determines would violate the ethical and religious principles of Catholic health facilities, such as expenses relating to abortions or sterilizations. An expense is not a Qualifying Medical Care Expense if it is reimbursable under the provisions of the Plan other than Section 3.4 of the Plan or under another health care plan.

Residential Treatment Center

A sub-acute facility-based program which delivers 24-hour per day, 7-day per week assessment and diagnostic services, and active behavioral health treatment to Participants who do not require the intensity of nursing care, medical monitoring and physician availability offered in an inpatient Hospital setting.

Retrospective Authorization

Approval by the Claims Administrator or the Plan's utilization vendor of services requiring Prior Authorization that is given after such services have been rendered, subject to the requirements provided in *Section 6* of this SPD.

Room and Board

Room and Board and special care unit accommodations furnished by a qualified Hospital while the Participant is Hospital Confined. Birthing Center accommodations are included.

Secondary

A source of benefits, such as a group health plan like SmartHealth, motor vehicle accident insurance, or money from a person or entity who caused injury, which does not have the initial responsibility to pay for benefits.

When the Plan is Secondary, the Primary source pays benefits first, and then the Plan will pay the difference between the amount paid by the Primary source of benefits and the amount that should have been paid by the Primary source of benefits. The Plan, however, will not pay more than the amount allowed under the Primary source of benefits nor will the Plan pay more than it would have if it were the only source of benefits.

SmartHealth

The Ascension SmartHealth Medical Plan, as amended from time to time.

SmartHealth Advisory Committee

A committee appointed by the Plan Administrator to handle second-level appeals.

SmartHealth Appeals Committee

A committee appointed by the Plan Administrator to handle first-level appeals.

Specialty Medication

A prescription drug that is either a self-administered (non-diabetic) injectable medication, a high-cost medication, or a medication that requires special handling, special administration, or monitoring. Examples of Specialty Medications include those used to treat chronic conditions or acute illnesses such as rheumatoid arthritis, psoriasis, cancer and multiple sclerosis.

Sponsor or Plan Sponsor

Ascension.

Spouse

The individual lawfully married to the Eligible Associate (even if legally separated), including an individual who is the common-law spouse of an Eligible Associate if the state in which the Eligible Associate resides recognizes common-law marriage.

Substance Use Disorder

A substance use disorder (SUD) is a mental disorder that affects a person's brain and behavior, leading to a person's inability to control their use of substances such as legal or illegal drugs, alcohol, or medications. Symptoms can range from moderate to severe, with addiction being the most severe form of SUDs.

Summary Plan Description (SPD)

One or more documents describing the terms and provisions of the Plan with respect to a Participant. Such documentation includes a formal SPD as required under Section 102 of ERISA and any summaries of material modifications or other written SPD supplements provided to Participants. (This document is an SPD).

Surgical Procedure

The incision, excision, debridement or cauterization of any organ or part of the body and the suturing of a wound; or the manipulative reduction of a fracture or dislocation or the manipulation of a joint including application of cast or traction; or the removal by endoscopic means of a stone or other foreign object from any part of the body or the diagnostic examination by endoscopic means of any part of the body; or the induction of artificial pneumothorax and the injection of sclerosing solutions; or arthrodesis, paracentesis, arthrocentesis and all injections into the joints or bursa; or obstetrical delivery and dilation and curettage; or biopsy.

Tier

A term that, prior to January 1, 2015, referred to the Ascension Network (Tier 1), the National Network (Tier 2) and/or Out-of-Network (Tier 3), depending on the context in which such term was used. The term “Tier” was removed from the Plan effective January 1, 2015. Although the Plan Administrator is phasing out the term, it may still occasionally appear in Plan-related communications and forms until all Plan-related documents have been updated.

Urgent Care Facility

A specialized facility or institution which may be freestanding or a distinct part of another facility or institution which is dedicated to the treatment of Urgent Care Medical Problems.

Urgent Care Medical Problem

An unexpected episode of illness or an injury requiring treatment that cannot reasonably be postponed for regularly scheduled care, but that is not life threatening, and does not require use of or treatment at an emergency room of a Hospital. Urgent Care Medical Problems include, but are not limited to, earache, sore throat and fever (not above 104 degrees).

USPSTF

The United States Preventive Services Task Force.