Ascension SmartHealth Medical Plan
(EPO Plan Option)

Summary Plan Description

Revised January 1, 2025

myAscension benefits

Ascension

Plan Outline and Schedule of Benefits

Ascension Wisconsin | Union
Ascension SmartHealth Medical Plan (EPO Plan Option) | Milwaukee, WI

Revision Date	January 1, 2025
Participating Employers	Ascension Wisconsin • RN CBA, Local 5000, AFT (U37) • Tech CBS, Local AF (U38)
Eligible Associates	Active full-time and part-time union Associates who are budgeted and working at least 20 hours per week.
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 Copays, Coinsurance and/or Deductibles.
Schedule of Benefits (Medical)	EPO Schedule of Benefits
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)	MaxorPlus
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.

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.

2025 Schedule of Benefits: Exclusive Provider Organization (EPO) Plan

Benefits	Ascension Network
Deductible • Individual • Family *All eligible expenses apply toward all OOP Maximums.	$500 $1,000
Coinsurance • Plan Pays • You Pay	85% 15%
Annual Out-Of-Pocket Maximum • Individual • Family All eligible expenses apply toward all OOP Maximums.	$4,500 $9,000
Lifetime Maximum	Unlimited

Services	Ascension Network	National Network
*** Services with an asterisk (*) may require Prior Authorization. For a list of services see: https://mysmarthealth.org/provider-resources/prior-authorization**		
Preventive Services Routine Physicals, Well Baby/Child Care, Routine Immunizations, Annual Gynecological Exam/Mammogram Screening, Colonoscopy See: mysmarthealth.org/member-resources/preventive-care	$0	No coverage without an approved referral
Facility Outpatient/Diagnostic Services Radiology, CT Scans, Radiation & Chemotherapy, Diagnostic Infertility Testing, Labs, Ultrasounds (non-Maternity)	15% after Deductible	No coverage without an approved referral
Medical Specialty (Physician administered or infusion therapy)* • Physician office/home • Outpatient	15% after Deductible(2) 15% after Deductible(2)	No coverage without an approved referral
Outpatient Surgery/Facility Charge* Anesthesia, Ancillary Services, Pathology, Physician Charges & Surgery	15% after Deductible(2)	No coverage without an approved referral
Outpatient Surgery/Physician's Office*	15% after Deductible(2)	No coverage without an approved referral
Physical/Occupational/Speech Therapy (Annual maximum for PT, OT, ST - 60 visits combined) • Occupational & Speech Therapy • Physical Therapy	15% after Deductible 15% after Deductible	No coverage without an approved referral
Dialysis (per treatment)	$25 Copay	Referral not required $25 Copay
Chiropractic Visit (Annual maximum - 35 visits) (Note: Includes manipulation and therapy; x-rays excluded.)	$30 Copay	No coverage without an approved referral

Facility High Tech Radiology (non-emergent)* (per visit unless otherwise noted) (Example: MRI and PET scans)	15% after Deductible[2]	No coverage without an approved referral
Office Visits (per visit unless otherwise noted) Primary Care (Family Practice/General Internal Medicine/Pediatrics)	$10 Copay	No coverage without an approved referral
Specialist (including OB/GYN)	$25 Copay	No coverage without an approved referral
Amwell Online Care • Behavioral Health Online Visit • Urgent Care Online	$10 Copay $10 Copay	N/A N/A
All other E-Visits • Primary Care • Specialist	$10 Copay $25 Copay	No coverage without an approved referral
Pre/Postnatal Care & Delivery	15% after Deductible	No coverage without an approved referral
• Maternity Imaging (Ultrasound)	15% after Deductible	No coverage without an approved referral
Mental Health[5] (per visit unless otherwise noted) • Individual Therapy/ Group Therapy[5] • E-Visits[5] • Partial Day Treatment/ Intensive Outpatient Therapy[5] • Inpatient Admission*[5]	$10 Copay $10 Copay 15% after Deductible 15% after Deductible[2]	Referral not required $10 Copay $10 Copay 15% after Ascension Network Deductible 15% after Ascension Network Deductible[2]
Substance Use Disorder[5] (per visit unless otherwise noted) • Individual Therapy/ Group Therapy[5] • E-Visits[5] • Partial Day Treatment/ Intensive Outpatient Therapy[5] • Acute Inpatient Care*[5]	$10 Copay $10 Copay 15% after Deductible 15% after Deductible[2]	Referral not required $10 Copay $10 Copay 15% after Ascension Network Deductible 15% after Ascension Network Deductible[2]
Emergency Care[5] (per visit unless otherwise noted) • ER Visit[5]	$500 Copay (Waived if admitted)	Referral not required $500 Copay (Waived if admitted)
• Urgent Care[5]	$50 Copay	Referral not required $50 Copay
• Ambulance[5]	15% after Deductible	Referral not required 15% after Ascension Network Deductible
• Medical Transfer/ Transport[5] (non-emergent)*	15% after Deductible[2]	Referral not required 15% after Ascension Network Deductible[2]
Inpatient Services (per admission)* Room and Board, Ancillary Services, Surgery, Anesthesia, Physician Charges	15% after Deductible [2]	No coverage without an approved referral
Inpatient Admission through Emergency Room (Note: Authorization required upon admission.)	15% after Deductible	Referral not required 15% after Deductible
Allergy Testing & Treatment	$25 Copay (per visit)	No coverage without an approved referral

Extended Care Facility (per admission)	15% after Deductible	No coverage without an approved referral
Home Health Care (Annual maximum - 100 visits)	15% after Deductible	No coverage without an approved referral
Hospice	15% after Deductible	No coverage without an approved referral
Other Services* • Durable Medical Equipment (DME)*	15% after Deductible (Annual out of pocket maximum $250)(2)	No coverage without an approved referral
Prosthetics & Orthotics (P&O)*	15% after Deductible(2)	No coverage without an approved referral
Foot Orthotics (2 pairs every 3 years)*	15% after Deductible(2) (per pair)	No coverage without an approved referral
Hearing Aid (3-year maximum - $2,000)	15% after Deductible	No coverage without an approved referral
Bariatric Surgery*	See Inpatient Services(2)	No coverage without an approved referral(2)
Organ/Bone Marrow/Other Transplants*	See Inpatient Services(2)	No coverage without an approved referral
Wellness/Disease Management (Diabetic Education per Medicare guidelines)	$0	No coverage without an approved referral
Smoking Cessation Intervention (Counseling)	$0	No coverage without an approved referral

***Notes: (1) Only care received within the Ascension Network (Tier 1) will be covered, unless you have an EPO Approved Referral or in the event of a medical emergency. If you receive care outside of the Ascension Network (Tier 1) without an EPO Approved Referral, you will pay the full cost of care. (2) Prior Authorization Required - failure to secure a Prior Authorization for certain services will result in no coverage/benefit paid under the Plan. To review a complete and up-to-date list of the services which require Prior Authorization, go to https://mysmarthealth.org/provider-resources/prior-authorization.**
(3) The Ascension network includes all Health Ministries of Ascension - including hospitals, clinics, affiliated providers and senior living facilities. (4) Any claim incurred through a non-Ascension Network provider could result in balance billing and/or additional charges to the member. (5) An EPO Approved Referral is required when using National Network providers (http://provider.bcbs.com) and Out-of-Network providers except under certain limited circumstances (Emergency Care or Mental Health and Substance Abuse services). All other services received from a nonAscension Network provider require an EPO Approved Referral.

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

Prescription Drugs - Go to www.mysmarthealth.org/plan-coverage/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 review the official Summary Plan Description, available online at www.mysmarthealth.org.

2025 Schedule of Benefits: Rx

Prior Authorization Required?	Yes - when applicable. Refer to current formulary.
Quantity Level Limits	Yes
Annual Out-of-Pocket Maximums	Applies to EPO Plan Participants $4,500 per individual/$9,000 per family
Mandatory Generic Provision	Yes. If you choose to receive a brand drug when a generic drug is available, your costs will be equal to the brand copayment plus the difference between the generic and the brand drug.
Mandatory Specialty Provision	For more information, please visit www.mysmarthealth.org/plan-coverage/pharmacy
Ascension Rx (30 day supply)	Generic: Up to $25 copay Preferred Brand: 20% (no minimum/maximum $65) Non-Preferred Brand: 30% (no minimum/maximum $165) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: $10 copay
Ascension Rx **(90 day supply)**	Generic: Up to $75 copay Preferred Brand: 20% (no minimum/maximum $200) Non-Preferred Brand: 30% (no minimum/maximum $500) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: $30 copay
Retail Benefit (30 day supply)	Generic: Up to $30 copay Preferred Brand: 25% (no minimum/maximum $125) Non-Preferred Brand: 35% (no minimum/maximum $175)
Ascension Rx Home Delivery (90 day supply)	Generic: Up to $40 copay Preferred Brand: 20% (no minimum/maximum $100) Non-Preferred Brand: 30% (no minimum/maximum $250) Ascension Preferred Diabetic Supplies (Strips/Lancets)/Insulin: $25 copay
Ascension Rx Specialty Pharmacy **(30 day supply)**	Specialized Generic: 40% (maximum $200) Preferred Specialty: 40% (maximum $250) Non-Preferred Speciality: 40% (maximum $400)
Pharmacy Benefit Manager (PBM)	MaxorPlus
Mail Order Benefit Manager	Ascension Rx Home Delivery
Specialty Drug Benefit Manager	Ascension Rx Specialty Pharmacy

Your Contact Information

For Questions About Eligibility, Filing a Change of Address, Reporting a Change Event (for example, marriage or the birth of a child) and/or Making Changes to Your Benefit Elections	**Ascension HR Central** 844-847-4747 8 a.m.-6 p.m. Eastern (7 a.m.-5 p.m. Central), Monday-Friday
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.
To Find a Physician or Hospital	Go online to https://mysmarthealth.org/plan-coverage/plan-documents and select **FIND A DOCTOR.** Or learn more about the Ascension Network and what each Tier level covers in the **Ascension Network** section of **Member Resources**.
To Request Prior Authorization (Physicians only)	**Ascension Insurance Medical Management Services** 1345 Philomena Street Suite #305 Austin, TX 78723 ***Standard Requests*** Online Provider Portal (registration is required) Fax: 586-693-4768 Email: shp-authorization@ascension.org ***Urgent Requests*** Phone: 844-217-8191 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. **The Plan will pay for services rendered by a National Network provider or an Out-of-Network provider only if there is a Plan-approved EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the Schedule of Benefits).*
To Appeal a Pre-Service, Concurrent Care or Time-Sensitive Medical Claim	**Level 1 Appeal** ***Medical Necessity Determinations*** Ascension Insurance Medical Management Services 1345 Philomena Street Suite #305 Austin, TX 78723 Fax: 586-693-4768 Email: shp-authorization@ascension.org Phone: 844-217-8191 8 a.m.-6 p.m. Eastern (7 a.m.-5 p.m. Central), Monday-Friday ***Administrative (Non-Medical Necessity) Determinations*** Automated Benefit Services for SmartHealth P. O. Box 321125 Detroit, MI 48232 Phone: 888-492-6811 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 Appeal a Post-Service Medical Claim	**Level 1 Appeal** SmartHealth Appeals Committee 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 Appeal a Non-Covered Benefit Medical Claim	**Level 1 Appeal** SmartHealth Appeals Committee 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
For Questions About Prescription Drug Coverage	**MaxorPlus** 888-820-4082 Representatives are available 24 hours a day, seven days a week.	
To Find an Ascension Rx Pharmacy Near You	Go to https://ascensionrx.com/ and click on **FIND AN ASCENSION RX PHARMACY NEAR YOU**.	
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** MaxorPlus Clinical Department 320 S. Polk Street Amarillo, TX 79101 Fax for Level 1 Appeals (including expedited appeals): 844-370-6203 Review Important Information About Your Appeal Rights Important Information About Your Appeal Rights for more details and an *Appeal Filing Form.*	**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** ***Medical Necessity Determinations*** Ascension Rx Specialty Pharmacy Attn: Medical Specialty Drugs 1345 Philomena Street Suite #305 Austin, TX 78723 Phone: 833-980-2352 (press 2) Fax: 512-831-5499 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	
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. Go online to 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* and *Schedule of Benefits* located at the beginning of this SPD, include requirements and provisions that apply specifically to your Health Ministry and Health Ministries that offer the SmartHealth Exclusive Provider Organization ("EPO") Plan option.

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. Under the EPO, you are required to use Ascension Network providers, unless you have an EPO Approved Referral. Using Ascension Network providers means that you will 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 under the EPO Plan option.

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 and the EPO Plan Option

When you first become eligible to enroll in SmartHealth, you will receive enrollment information that explains how to enroll, the deadline by which you must make your elections, 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* at the beginning of this SPD for your Health Ministry's eligibility and participation requirements. Also see *Section 2* for additional details about Eligible Dependents.

If you don't enroll when first eligible, you may enroll later at the next open enrollment date (or earlier if your situation changes and the Plan allows enrollment due to such change). You must provide notification of any change (marriage, birth of a child, divorce, 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 *Schedules of Benefits* spells out the details of your EPO coverage and Prescription Drug Coverage under the Plan. See the *Schedules of Benefits* at the beginning of this SPD for specific details. Note:

You and the Plan share the cost of your medical care. In addition to both the Plan and you paying a share of the premium, you also pay Copays (as provided in your EPO *Schedule of Benefits*) when you receive medical care. The Plan will pay any amounts in excess of the Copays of Covered Expenses. If you reach the applicable Annual Out-of-Pocket Maximum, the Plan will pay 100% of Covered Expenses incurred for the remainder of the Plan Year.

Cost-Share / Cost-Shares / Cost-Sharing
For purposes of EPO coverage under the Plan, these terms refer to the amounts owed by the Participant outside of payment, if any, by the Plan, whether through Copays and/or Balance Billing amounts. See *Section 4* for specific details about your Prescription Drug Benefits.

Notwithstanding the preceding, you are also responsible for any costs you incur that are excluded from Covered Expenses or costs that exceed any maximums or limitations. In addition, if you use Out-of-Network EPO Referred Providers pursuant to an EPO Approved Referral, you may receive bills for charges in excess of the Maximum Payable Charge allowed by the Plan (referred to as "Balance Billing"). Benefits are subject to Maximum Payable Charge limitations, benefit maximums, exclusions, and limitations. **Certain services require Prior Authorization.**

Your coverage is provided through the EPO Network. The EPO Network consists of Ascension Network providers and EPO Referred Providers. An EPO Referred Provider is either a National Network or Out-of-Network provider that provides services to you pursuant to an EPO Approved Referral.

An **EPO Approved Referral** is a referral by an Ascension Network Physician to a Physician or facility that has been approved by the Plan Administrator or its designee and that meets the requirements summarized in *Section 8*.

If you receive services from an EPO Network provider, those services are covered by the Plan, subject to the conditions discussed in this SPD. **Except in certain limited circumstances, such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), if you receive services from a provider or facility that is not in the EPO Network, the Plan will not pay anything for those services and the cost of those services will not count towards any Copay, Annual Out-of-Pocket Maximum or similar accumulator.** Therefore, it is very important that you receive services from EPO Providers whenever possible.

Because the EPO Network consists of different types of providers that can affect how much you pay for services, it is important to know the difference between providers in the Ascension Network and National Network and providers who are Out-of-Network.

- **Ascension Network** – An expanded network of Health Ministry doctors and facilities. When you use Ascension Network providers, you get more competitive benefits – because we are a healthcare provider. Ascension Network providers are always in the EPO Network.

- **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 via an EPO Approved Referral because we recognize that at times you may need care that is not available from an Ascension Network provider. National Network providers are considered part of the EPO Network only if you receive an EPO Approved Referral before you receive services from the National Network provider.

- **Out-of-Network** – Other doctors and facilities who are not participating in the Ascension or National Network. Out-of-Network providers are considered part of the EPO Network only if you receive an EPO Approved Referral before you receive services from the Out-of-Network provider. Your services may be covered; however, you still may be subject to Balance Billing from the provider even though you received an EPO Approved Referral. See *How Expenses Are Covered* in *Section 3* for details.

If you visit a National Network or Out-of-Network provider without an EPO Approved Referral, the Plan will not cover the cost of the services you receive except in certain limited circumstances such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

The provider you choose when you need care determines how much you pay. If you visit an Ascension Network provider, the amount you pay will typically be the lowest. If you need a referral, it is best from a cost perspective to be referred to a National Network provider rather than an Out-of-Network provider because if you are referred to an Out-of-Network provider, you may receive bills from the provider for charges in excess of the Maximum Payable Charge allowed by the Plan. Keep in mind that if you do need a referral, the referral must be approved prior to your visit or the Plan will not pay for the services you receive. See *Section 8* for rules governing EPO Approved Referrals.

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.

Before leaving employment or requesting a leave of absence, discuss your benefit options with Ascension HR Central. 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 any 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, 2025** 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.

As noted above, the information in this SPD is intended to be current as of January 1, 2025 unless otherwise provided. However, certain information changes from time to time, for example, the composition of the Ascension Network and National Network, Copays, and 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.

Section 2: Eligibility and Participation

Eligibility

Eligible Associates

All Associates in your Health Ministry's class of Eligible Associates may enroll. (See the *Plan Outline* 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 12 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 13* 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 any Cost-Sharing requirement.

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.

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.

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* at the beginning of this SPD for your Health Ministry's Entry Date.

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.

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 2* for details.

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.

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.

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.

Important Reminder

If you wish to make a change to your Plan election as a result of a Change Event, you must notify Ascension HR Central of that Change Event *and* make the Plan election change within 30 days of the event.

For example, if you want to cover your newborn baby under SmartHealth, **you must make the notification AND change your SmartHealth election within 30 days of your baby's birth**. **Otherwise, your baby will not be covered under the Plan as of date of birth.**

You must notify Ascension to add your baby to your Plan coverage as described above even when your baby is born at an Ascension Health Ministry Hospital. The Hospital is not permitted to inform Ascension of any Change Events since any such change is considered your personal and protected health information.

To change an election mid-year as a result of a Change Event, you must submit documentation of the Change Event and make the election change within 30 days of that event. If the change is submitted within the 30-day period, it will be effective on the applicable 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 can be made to your elections. However, you may make the necessary changes 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 Ascension HR Central 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 12* for details. Different rules may apply in the event of salary continuation or severance payments.

Termination of Coverage at end of Authorized Leave Period

If coverage does not end sooner as provided above (for example, due to an authorized leave or other special situation) and you have not returned to work, your coverage will end on the later of the following dates:

- 12 months after the last day you are actively at work; or
- The last day of any leave period authorized by Ascension, including extensions mandated by federal law.

Termination of Coverage 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 12* 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 EPO with the new employer, your benefit elections will not change.

If the EPO is not available when you transfer to the new Participating Employer, 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 upon your transfer.

Section 3: Your EPO Medical Benefits

SmartHealth offers you comprehensive coverage for healthcare through the EPO Network. At enrollment, you do not need to choose a doctor 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.

For additional details about the EPO Plan option, see the *Plan Outline and Schedule of Benefits* located at the beginning of this SPD or visit https://mysmarthealth.org/.

Your Coverage

Enrolling

The *Schedule of Benefits* (located at the beginning of this SPD) specifies the level of benefits that will be paid for expenses covered under the EPO Plan option.

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

Obtaining Care – Choosing a Provider

The EPO Plan option only pays for care you receive at an EPO Network provider. Therefore, when choosing a doctor or other provider or facility, you should go online to the **Find a Doctor** section of https://mysmarthealth.org/. Be sure to check that the doctor or facility you choose is a participating Ascension SmartHealth Tier 1 Network provider or facility before you schedule your appointment. Ascension Network providers and facilities are always in the EPO Network and will be covered under the Plan, subject to the conditions discussed in this SPD.

The **EPO Network** consists of the Ascension Network and EPO Referred Providers. An EPO Referred Provider is a National Network or Out-of-Network provider that provides services pursuant to an EPO Approved Referral.

If a service you need does not exist within the Ascension Network and you need an EPO Approved Referral, your Ascension Network provider must submit a referral request, subject to review and approval by SmartHealth. Referrals should be within the Blue Cross Blue Shield Network (*i.e.*, the National Network) whenever possible. If this referral request is denied, you or your provider can submit an appeal.

If you visit a non-EPO Network provider or facility without an EPO Approved Referral, you will be responsible for the full cost of care except in certain limited circumstances such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

How Expenses Are Covered

The Plan covers expenses that are identified as "Covered Expenses" under SmartHealth. For most Covered Expenses, you and SmartHealth share the expense as stated in the *Schedule of Benefits*. 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 and Cost-Share percentage listed on your *Schedule of Benefits* for care received from Ascension Network or National Network providers.

- 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*.
- Any expense covered under SmartHealth is identified as a Covered Expense; any service identified as an exclusion is not covered under SmartHealth. See *Section 5* for additional details.
- Prior Authorization may be required. (See *Section 6* for more information about Prior Authorization Requirements.)
- If you receive an EPO Approved Referral to an Out-of-Network provider and that provider charges fees greater than the Maximum Payable Charge, you may be charged the difference, also referred to as "Balance Billing." Balance Billing amounts do not count toward your Copays, Annual Out-of-Pocket Maximum or similar accumulator.
- Except in certain limited circumstances, such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), if you receive services from a provider or facility that is not in the EPO Network, the Plan will not pay anything for those services and the cost of those services will not count towards any Copay, Annual Out-of-Pocket Maximum or similar accumulator.

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 from a National Network provider with an EPO Approved Referral. However, all benefits under the Plan are subject to certain maximums (as listed in the following table), applicable Prior Authorization and Retrospective 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.

Maximums

Covered Expenses paid for certain services or supplies will not exceed the maximums listed in the following table:

Maximums Each Year (January 1-December 31)	
Annual Mammogram	1 test
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.
Maximums Each Year (January 1-December 31)	Maximums Each Year (January 1-December 31)

Maximums Each Year (January 1-December 31) (continued)	
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 – each type of therapy is considered a single visit. For example, if you have a physical therapy and a speech therapy appointment on the same day, you will incur 2 visits for that day. • Prior Authorization is required for visits in excess of 60.
Diabetes Education	1 program
Prescription Support Stockings	4 pairs
Therapeutic shoes for diabetes mellitus	• 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

The *Schedule of Benefits* lists a flat-dollar Copay for an office visit or E-visit within the Ascension Network. 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, you will be responsible for the full cost of such services unless a Cost-Share provision applies. 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 and you are not admitted to the Hospital, an ER Visit Copay will apply as listed in the *Schedule of Benefits*. If you are admitted to the Hospital, the ER Visit Copay will not be charged**,** and you will receive benefits as listed in the *Schedule of Benefits*.

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 an Emergency Room visit or admission), these Covered Expenses will be covered as listed in the *Schedule of Benefits*. Such services in a National Network or Out-of-Network Hospital will only be covered with an EPO Approved Referral.

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.

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/plan-coverage/plan-documents to determine the availability of Ascension Network providers in the area you are traveling to. If none are available, the Plan will cover Urgent Care, or in the event of a Medical Emergency, emergency care.

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.

The Plan does not cover vaccines for travel.

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.

Section 4: Your Prescription Drug Benefits

Prescription Drug Services

Prescription Drug Benefits are available under the Plan as described in this section.

Ascension Rx Community Pharmacy

Participants may purchase Covered Drugs, including, but not limited to, 30-day and 90-day supplies of Maintenance Medications, at an in-house Ascension Rx Community Pharmacy subject to any Cost-Sharing and Annual Out-of-Pocket Maximum specified in your *Schedule of Benefits*. To determine if an Ascension Rx Community Pharmacy is located near you, go to https://ascensionrx.com/ and click on **FIND AN ASCENSION RX PHARMACY COMMUNITY NEAR YOU**.

Ascension Rx Home Delivery

Participants may purchase Covered Drugs, including 30-day and 90-day supplies of qualifying Maintenance Medications, through Ascension Rx Home Delivery subject to any Cost-Sharing and Annual Out-of-Pocket Maximum specified in your *Schedule of Benefits*.

Retail Pharmacies

Participants may:

- Purchase Covered Drugs at any *participating* retail pharmacy subject to any Cost-Sharing amounts 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 amounts specified in the *Schedule of Benefits*.

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

Ascension Rx Maintenance Medications Requirements

Maintenance Medications are prescription drugs that generally require regular use (for example, daily, weekly or monthly) to treat a condition that is considered chronic or long-term (for example, high blood pressure, diabetes, allergies, asthma, etc.).

In accordance with the Plan, any **90-day supply of a qualifying Maintenance Medication** must be filled or refilled at an Ascension Rx Community Pharmacy or through Ascension Rx Home Delivery in order for the cost paid by the Participant to count towards any Deductible, Copay, Coinsurance, Annual Out-of-Pocket Maximum or similar accumulator (collectively known as "accumulators"). If a Participant purchases the 90-day supply at a participating or nonparticipating retail pharmacy, they will be responsible for the full cost and such cost will not count toward any accumulator.

The 90-day Ascension Rx Maintenance Medication requirement described above will also apply to 30-day supplies of qualifying Maintenance Medications effective for markets and ministries in phases throughout 2025.

Once the new Ascension Rx medication requirements become applicable to a market/ministry, a 30-day (or 90-day) supply of a qualifying Maintenance Medication is only considered a Covered Drug under the Plan if purchased through an in-house Ascension Rx Community Pharmacy or Ascension Rx Home Delivery. If not, the Participant will be responsible for the full cost and such cost will not count toward any accumulator. **The new Ascension Rx medication requirements will become final for all markets/ministries no later than October 1, 2025.**

For additional details about these requirements, how they apply to current or new associates, or to determine if your current prescription is a qualifying Maintenance Medication, go online to the Maintenance Medication List section of https://www.mysmarthealth.org/.

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, Coinsurance, 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 any Cost-Sharing and Annual Out-of-Pocket Maximums stated in your *Schedule of Benefits*.

Application of Cost-Sharing Amounts
Except with respect to Participants who participate in a high-deductible health plan option and/or except as provided in an Addendum, any amount that the Participant is required to pay when purchasing prescription medication will not apply to the Deductible.

Prescription Drug Formulary: Covered and Excluded Medications
The Prescription Drug Formulary ("Drug Formulary") is a comprehensive list of medications covered by SmartHealth. This list is reviewed and updated throughout the Plan Year and therefore is subject to change. Medications may be added to the Drug Formulary throughout the year. Some brand name and specialty medications may be removed from the formulary as generics or biosimilar drugs become available. Medications may also be removed in the event of FDA market withdrawals. You will be notified in advance in writing if you have been prescribed a medication that is being removed from the Drug Formulary. You may also go online to https://ascensionsmarthealth.maxorplus.com/formulary/ to determine if a particular medication is covered under the Plan.

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 such individual 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)
A pharmaceutical manufacturer may sponsor a PAP for individuals who cannot afford their prescriptions – through a PAP, prescription drug assistance may be provided by the manufacturer and not by Ascension Rx or the Plan. Any amounts applied to the cost of prescription drugs under a PAP do not count towards any Deductible, Coinsurance, Copay, Annual Out-of-Pocket Maximum or similar accumulator under this Plan.

Note: The pharmaceutical manufacturer may change or terminate their PAPs at any time during the year. If that happens, the Participant will pay the regular Copay for the applicable prescription drug based on the Plan option they elected.

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, you and SmartHealth share the expense as stated in your *Schedule of Benefits*.

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, Annual Out-of-Pocket Maximum or similar accumulator.

Except in certain limited circumstances, such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), if you receive services from a provider or facility that is not in the EPO Network, the Plan will not pay anything for those services and the cost of those services will not count towards any Copays, Annual Out-of-Pocket Maximum or similar accumulator.

Subject to the limitations described below, the Plan pays for all preventive care services received from Ascension Network; these services received from National Network providers are only covered with an EPO Approved Referral. Such preventive care services are not subject to Copays or similar accumulators.

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.

Important Reminder: Some Covered Services may require Prior Authorization. See *Section 6* for additional information. Also, to review a complete and up-to-date list of services that require Prior Authorization, go to https://mysmarthealth.org/, select **Member Resources** and go to the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the **Prior Authorization** section or call ABS at **888-492-6811** to speak to a customer service representative.

Alternative Treatment Plans
In addition to the benefits described in the *Schedule of Benefits*, the Plan Administrator has the discretion to offer benefits for services furnished pursuant to a Plan-approved alternative treatment plan. 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 *Schedule of Benefits*. 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. 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.

Ambulance, Transfer and Inter-Facility Transport	
The Plan covers: ● 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.	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. 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. 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. 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.
Blood	
The Plan covers expenses for: ● Blood and blood plasma, and their administration. ● Autologous blood transfer and blood storage.	
Cardiac Rehabilitation	
The Plan covers expenses for: ● Cardiac Rehabilitation–Phase I provided in Inpatient setting. ● Cardiac Rehabilitation–Phase II for patients who: – 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.	<u>Exclusions</u> – Expenses will NOT be paid for: ● Cardiac Rehabilitation–Phase III.

Chimeric Antigen Receptor T-Cell (CAR-T) Therapy	
The Plan covers expenses for: ● Treatment for one course of treatment for CAR-T therapy when approved by the Plan Administrator in accordance with the SmartHealth CAR-T Treatment Clinical Policy ("CAR-T Policy"). ● A second CAR-T therapy regimen will be covered only when a new primary cancer diagnosis is made by the treating oncologist and the required patient conditions are met as outlined in the CAR-T Policy.	Exclusions – Expenses will NOT be paid for: ● Additional CAR-T treatments for the same cancer diagnosis. ● Costs incident to additional CAR-T treatments (for example, labs, outpatient visits, inpatient stays, etc.) will be covered, but only if such additional incidental costs and CAR-T treatments are a part of, and covered by, an approved clinical trial. Note: As new CAR-T therapies are developed, the Plan Administrator will consider requests for new-to-market CAR-T therapy after the new CAR-T therapy has been approved by the United States Food and Drug Administration, and in accordance with the CAR-T Policy.
Cosmetic Surgery	
The Plan covers expenses for: ● Cosmetic Surgery when performed to correct deformities under the following circumstances: – 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.	Exclusions – Expenses will NOT be paid for: ● Breast implants for solely cosmetic reasons, except when specifically provided under covered services.
Dental Services	
The Plan covers: ● Treatment of Injuries to sound natural teeth under the following circumstances: – 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; – 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.	Exclusions – Expenses will NOT be paid for: ● 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.

Dental Services (continued)	
The Plan also covers: ● 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. The Plan also covers Hospital Charges for: ● 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.	
Dialysis	
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. Note: The Plan will be the Secondary payer regardless of whether the Participant actually signs up for Medicare.	
Durable Medical Equipment	
The Plan covers Durable Medical Equipment (for example, standard wheelchair, Hospital bed, oxygen and equipment, etc.) as follows: ● 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 with an EPO Approved Referral) 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.).	Exclusions – Expenses will NOT be paid for: ● 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. ● First aid or precautionary equipment (for example, automatic external defibrillator [AED]).

Durable Medical Equipment (continued)	
	● Multiple-function hardware devices that do not meet the definition of Durable Medical Equipment, because they are not primarily intended for medical purposes, include, but are not limited to: – Desktop and laptop computers. – Personal digital assistants (PDA). – Smartphones. – Tablet computers. – Internet or phone services. ● Vehicle modifications (for example, wheelchair vans, lifts attached to vehicles for scooters or wheelchairs). ● Accessory add-ons and upgrades when a basic (standard) Durable Medical Equipment item meets the Participant's functional needs. ● Deluxe equipment when basic (standard) equipment is available and meets the Participant's functional needs. ● Equipment and modifications/upgrades to equipment when used primarily for leisure or recreational activities (for example, special wheelchair wheels for sport activities, adaptations for beach use, skiing). ● Redundant or back-up Durable Medical Equipment item(s) not used as the primary device to meet the Participant's functional needs (that is, more than one of the same Durable Medical Equipment).
Emergency Care	
The Plan covers: ● Emergency Room visit. ● Urgent Care Facility visit.	

Extended Care Facility

The Plan covers:

- Room and Board.
- Other services and supplies ordered by a Physician and furnished by the Extended Care Facility for Inpatient medical care.
- 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.

Exclusions – Expenses will NOT be paid for:

- Custodial Care.
- Cost of schooling provided by the facility.

Hearing

The Plan covers:

- Diagnostic hearing exams.
- Hearing aids – up to $2,000 per Participant every 3 years when received from a designated provider based on the *Schedule of Benefits*.
- Hearing aid dispensing fee, including hearing aid check (up to $250 every 3 years).
- Cochlear implants.

Exclusions – Expenses will NOT be paid for:

- Hearing aid batteries.

Home Health Care

The Plan covers:

- Part-time or intermittent nursing care by or under the supervision of a registered nurse (up to 100 visits per year) Note: 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; limited to 60 visits per year for all therapies combined. For example, if you have a physical therapy and a speech therapy appointment on the same day, you will incur 2 visits for that day. Prior Authorization is required for visits in excess of 60.
- Medical supplies.
- Masters-prepared social workers (MSW).

Hospice

The Plan covers the following services ordered by a Physician:

- 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	
The Plan covers: ● 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. ● 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.	<u>Exclusions</u> – Expenses will NOT be paid for: ● 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.

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 will only be paid if the hospital confinement is at an Ascension Network hospital or through an EPO Approved Referral at a non-Ascension Network hospital.	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	
The Plan covers: ● Charges for or in connection with a mastectomy consistent with the Women's Health & Cancer Rights Act of 1998 including: – 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 is subject to Cost-Sharing.	Exclusions – Expenses will NOT be paid for custom-made prostheses.

Maternity and Newborn Care	
The Plan covers: ● Hospital admission of 48 hours following a vaginal delivery, or 96 hours following a Cesarean delivery, for an eligible admission. Note: There is no per admission Copay due for an initial newborn confinement. However, if the newborn remains in the hospital while the mother is discharged, standard Cost-Sharing for that newborn will apply. ● Care for routine nursery charges for a newborn child while the mother is confined in the Hospital. Note: 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. ● Lactation support, supplies and counseling as provided for under applicable policies of the Plan Administrator or the Plan's utilization vendor. ● Birthing and delivery services by a Midwife in an approved Hospital or Birthing Center. ● Circumcisions. ● Home uterine monitoring, including devices.	Exclusions – Expenses will NOT be paid for: ● 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. **Important Reminder** Be sure to notify Ascension HR Central of the birth of a child and make any related benefit election changes within 30 days of the newborn's date of birth. Otherwise, your baby will not be covered under the Plan as of date of birth. See *Change Events* in *Section 2* for details.

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 each disorder diagnosis. ● 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.	<u>Exclusions</u> – 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.

Mutually Exclusive Services	
Each Plan Year, only 2 of the following 3 services will be considered Covered Expenses under the Plan: ● 1 annual well-woman visit with a primary care provider. ● 1 annual gynecological examination. ● 1 natural family planning examination.	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. Note: The Plan will not cover 2 routine physical examinations per year; the Plan will only cover 1 routine physical per year.
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).	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 unless provided by an Ascension Network provider or, if an Ascension Network provider is not available, by a National Network or Out-of-Network provider with an EPO Approved Referral. ● 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)	
● Physical therapy by a licensed physiotherapist. Limited to 60 visits per year for all physical, occupational and speech therapy visits combined. Prior Authorization is required for visits in excess of 60. ● Occupational therapy by a licensed occupational therapist. Limited to 60 visits per year for all physical, occupational and speech therapy visits combined. Prior Authorization is required for visits in excess of 60. ● Sleep studies provided in a facility or private residence. ● Speech therapy by a licensed, qualified speech therapist. Limited to 60 visits per year for all physical, occupational and speech therapy combined. Prior Authorization is required for visits in excess of 60. Such therapy must be for the purpose of restoring loss of the ability to swallow, speech loss or correcting an impairment due to: – 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) under the following circumstances: – The treatment must be Medically Necessary, and must be for a neuromusculoskeletal disorder, and – The treatment plan must be clearly documented, and – For home visits, the Participant must be homebound. ● Magnetic resonance guided focused ultrasound for the treatment of leiomyomata. ● Charges for temporomandibular joint (TMJ) appliances.	**Important Reminder** As the dot points to the left explain, the 60-visit annual maximum for physical therapy, occupational therapy and speech therapy applies to all of these therapies combined – each type of therapy is considered a single visit. For example, if you have a physical therapy and a speech therapy appointment on the same day, you will incur 2 visits for that day. <u>Exclusions</u> – With respect to chiropractic services, expenses will NOT be paid for: ● Virtual visits. ● Services that are considered experimental or investigative.

Prescribed Medical Supplies	
The Plan covers: ● 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.	Exclusions – Expenses will NOT be paid for: ● 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.). ● Weight loss and anti-obesity medications such as Wegovy, Saxenda and Zepbound. The anti-obesity medications Adipex, Alli, Benzphetamine, Contrave, Diethylpropion, Imcivree, Lomaira, Orlistat, Phendimetrazine, Phentermine, Plenity, Qsymia, Resveratrol and Xenical are also excluded. This exclusion will apply to new weight loss drugs that become available during the Plan Year. Note: The Participant will be required to pay the full cost of any of the OTC, weight loss or anti-obesity medications, or medication classes listed above, and such costs will not count towards any Copays, 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 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 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 to the extent such services (i) are not covered under the preceding dot point 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. – 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: ● **ACA Health Insurance Exchange**: https://www.healthcare.gov/coverage/preventive-care-benefits/. ● The Preventive Care section under **Additional Resources** in the **Member Resources** section of https://mysmarthealth.org/. This section of the website includes: – The Full preventive services code list. – An Overview of Preventive Care. Important Note: The Preventive Care Services list in this SPD provides just an abbreviated summary. Go online to view the Full preventive services code list, 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.

Prosthetics and Orthotics (P&O)	
The Plan covers: ● 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.	Exclusions – Expenses will NOT be paid for: ● 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. ● Accessory add-ons and upgrades when a basic standard item meet the member's functional needs.

Substance Use Disorder	
The Plan covers Substance Use Disorder 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. ● 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.	<u>Exclusions</u> – Expenses will NOT be paid for: ● 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	
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.	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. The Plan also excludes vaccines for travel.
Treatment or Services Outside of the United States	
Treatment or services rendered outside of the United States, its protectorates, Canada or Mexico, but only if the treatment and/or services are rendered in connection with a Medical Emergency.	
Vision	
Eyeglasses, including frames, or contact lenses following cataract surgery or contact lenses for the diagnosis of keratoconus up to a $250 maximum.	Except as provided in this section, expenses will NOT be covered for: ● 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	
The Plan covers: ● Physician-supervised weight loss services. ● Nutritional counseling (maximum of 3 visits per year).	Exclusions – Expenses will NOT be paid for: ● 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	
The Plan covers: ● 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: – 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 ≥ two years following a primary bariatric surgery procedure must meet the initial Medical Necessity criteria for surgery.	<u>Exclusions</u> – Expenses will NOT be paid for: ● 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	
The Plan covers: ● Diabetes education and dietetic support in accordance with Medicare guidelines. ● Smoking cessation intervention (counseling).	

Other Services	
The Plan covers: ● Autism/applied behavior analysis therapy, subject to Prior Authorization. ● 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: – 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).	Exclusions – Expenses will NOT be paid for: ● 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). **Important Reminder** Certain other services may require Prior Authorization. **To review a complete and up-to-date list of services that require Prior Authorization,** go to https://mysmarthealth.org/, select **Member Resources** and go to the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the Prior Authorization section or call ABS at **888-492-6811** to speak to a customer service representative.

Additional Exclusions (General and Specific)

Additional exclusions (general and specific) are listed below.

Important Reminder: When Prior Authorization or Retrospective Authorization rules apply, any such services will not be covered by the Plan unless your doctor, pharmacist or other healthcare provider obtains Prior Authorization or Retrospective Authorization as explained in *Section 6*. Regardless, it's important to remember that is ultimately your responsibility to ensure that any required Prior Authorization or Retrospective Authorization is obtained.

General Exclusions

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

- 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.
- 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.

General Exclusions (continued)

- 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 (as approved by the Plan Administrator); 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.
- Any services and/or supplies incurred with non-EPO Network providers.
- 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.
- Any form of therapy provided at a school or school-related facility by a therapist employed by such school or an entity related to such school (including without limitation, a school district).

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.
- Educational testing, therapy, or training.
- Exercise programs.

Specific Exclusions (continued)

- 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.
- 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.
- Vaccines for travel.

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 Durable Medical Equipment. Any Inpatient Hospital admission 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 9*.

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. **This list is a high-level overview. Therefore, other services may also require Prior Authorization. To review a complete and up-to-date list of services that require Prior Authorization,** go to https://mysmarthealth.org/, select **Member Resources** and go to the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the Prior Authorization section or call ABS at **888-492-6811** and speak to a customer service representative.	
Inpatient admissions/services	● Inpatient Hospital (medical and surgical). ● Acute inpatient rehabilitation. ● Long-term acute care (LTAC). ● Skilled nursing facility (SNF).
Outpatient services	● Physical/occupational/speech therapy; maximum of 60 visits per year for all therapies combined. For example, if you have a physical therapy and a speech therapy appointment on the same day, you will incur 2 visits for that day. Prior Authorization must be obtained for visits in excess of 60. ● Sleep studies that are provided in a facility. ● Physical medicine and rehabilitation day programs.
Behavioral health services	● Inpatient admissions. ● Residential treatment center (RTC) admissions. ● Neuropsychological testing. ● Autism/applied behavior analysis therapy.
High Tech Radiology Procedure	● PET scans, MRIs, MRAs, etc. ● Cardiac Nuclear Imaging.
Genetic Testing	● All genetic laboratory testing.
Medical Benefit/ Medical Specialty Drugs	● 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. **This list is a high-level overview. Therefore, other services may also require Prior Authorization. To review a complete and up-to-date list of services that require Prior Authorization,** go to https://mysmarthealth.org/, select **Member Resources** and go to the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the **Prior Authorization** section or call ABS at **888-492-6811** and speak to a customer service representative.	
Procedures	● 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/Weight Loss 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	● 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	● New emerging technology/procedures, as well as existing technology and procedures applied for new uses and treatments.

List of Services Requiring Prior Authorization	
This list applies to all Health Ministries and all providers. **This list is a high-level overview. Therefore, other services may also require Prior Authorization. To review a complete and up-to-date list of services that require Prior Authorization,** go to https://mysmarthealth.org/, select **Member Resources** and go to the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the **Prior Authorization** section or call ABS at **888-492-6811** and speak to a customer service representative.	
Customized Orthoses and Prosthetics (Including Accessories/Components)	● Custom ankle-foot orthoses. ● Custom knee-ankle-foot orthoses. ● Custom knee braces. ● Custom limb prosthetics including accessories/components. ● Artificial eye or ocular prosthesis.
Air Ambulance Transport Services	● Prior Authorization is required for all inter-facility or hospital to hospital air transport both fixed wing and rotor wing aircraft. ● Elective/non-emergency air ambulance services. Note: See the *Ambulance, Transfer and Inter-Facility Transport* section of *Covered Expenses and Exclusions* of *Section 5* for additional details.
Durable Medical Equipment (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 medical care, see "Pre-Service Claims" and "Time-Sensitive Claims" in *Section 9*.

Section 7: Care Management

The Ascension Care Management (ACM) team is made up of registered nurses, behavioral health specialists, wellness coaches and community health workers. They work in collaboration with providers and multidisciplinary team members to help Participants manage their medical conditions more effectively. Care managers can also provide Participants with education, resources and encouragement to support them along their healthcare journey. These services include:

- Disease or complex disease management.
- Behavioral health.
- Transitional care management.
- High-risk maternity program.
- Wellness and prevention programs.
- Resource referrals.

These services are available at no extra cost to SmartHealth Participants. Care managers will assess a Participant's diagnosis, health history, current needs and treatment plan in order to determine the appropriate level of involvement. The level of involvement may include:

- Ongoing telephone contact with the Participant.
- Assisting providers and Participants in coordinating ancillary services.
- Education about Illness or Injury.
- Facilitating access to community services and resources.

Learn more online or download the ACM program flyer. To contact ACM, email **acmmembers@ascension.org** or call **855-288-6747**.

Section 8: Special EPO Provisions

As explained previously, the EPO Plan option only covers services received from Ascension Network Providers or facilities except under certain limited circumstances such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*). If there is a specialist or service not available within the Ascension Network, an Ascension Network provider can request an EPO Approved Referral to a National Network or Out-of-Network provider or facility.

EPO Referred Provider

An "EPO Referred Provider" is a National Network or Out-of-Network provider or facility that provides services to a Participant pursuant to an **EPO Approved Referral**.

The EPO referral submitted by the Ascension Network provider will be reviewed to determine if the requested specialist or service is a Qualifying Medical Care Expense and Medically Necessary and appropriate. If so, the EPO referral will be approved and deemed an **EPO Approved Referral**. The National Network or Out-of-Network provider or facility specified in the EPO Approved Referral will then be considered an **EPO Referred Provider** but only for purposes of the specific EPO Approved Referral.

The **EPO Network i**ncludes:

- Ascension Network providers and facilities.
- National Network and Out-of-Network providers and facilities who have been deemed EPO Referred Providers for specific services covered under an EPO Approved Referral.

If you receive the approved services from an EPO Network provider or facility, those services are covered by the Plan, subject to the conditions discussed in this SPD. If you receive services from a non-EPO Network provider or facility, the Plan will not pay anything for those services and the cost of those services will not count towards any Copay, Annual Out-of-Pocket Maximum or similar accumulator. **Therefore, it is very important that any National Network or Out-of-Network provider or facility receives an EPO Approved Referral before you receive services or treatment from that provider or facility.**

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. Ascension Network providers are automatically in the EPO Network.

National Network – A network made up of doctors and facilities who have an agreement with SmartHealth but are not affiliated with the Health Ministry.

Out-of-Network – Other doctors and facilities who are not participating in the Ascension or National Networks.

Important Note: Under certain limited circumstances, such as an **EPO Referral Exception** (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), the Plan will cover the cost of services you receive if you visit a National Network or Out-of-Network provider or facility without an EPO Approved Referral. See *Section 3* of this SPD for details on what constitutes a Medical Emergency and the *Schedule of Benefits* for specific details on services provided by a National Network or Out-of-Network provider or facility that do not require an EPO Approved Referral. See the next page of this SPD for additional information about EPO Referral Exceptions.

EPO Approved Referrals

As described above, an Ascension Network provider must submit a referral to a National Network or Out-of-Network provider or facility to the Plan Administrator or its designee (currently Ascension Insurance Medical Management Services) for review. EPO Approved Referrals are subject to the following:

- If the referral request is denied, you or your National Network or Out-of-Network provider can submit an appeal.
- An EPO Approved Referral must be granted before services are provided.
- An EPO Approved Referral will be valid for 90 days. After 90 days, a new EPO Approved Referral must be granted.
- An EPO Approved Referral only applies to the specified National Network or Out-of-Network services (e.g., specialist referrals, lab tests, etc.) outlined in the EPO Approval Letter. If additional services are needed, a new request for an EPO Approved Referral must be submitted by your Ascension Network provider to Ascension Insurance Utilization Management Gateway for review and approval.

EPO Referral Exceptions

An EPO Approved Referral is not needed in certain limited circumstances. This is called an "EPO Referral Exception." An EPO Referral Exception occurs when you have a Medical Emergency (or as otherwise listed on the *Schedule of Benefits*) or if any of the following exceptions apply:

- Facility Driver Exception (Ascension Network Facility). This exception applies if you:
  - Incur costs for services at an Ascension Network facility; and
  - Incur associated costs for services rendered by one or more National Network and/or Out-of-Network providers at such Ascension Network facility; and
  - Had no control over the selection of such provider(s).
- Facility Driver Exception (National Network or Out-of-Network Facility). This exception applies if you:
  - Incur costs for services at a National Network or Out-of-Network facility with an EPO Approved Referral; and
  - Incur associated costs for services rendered by one or more National or Out-of-Network providers at such National Network or Out-of-Network facility; and
  - Had no control over the selection of such provider(s).
- Radiology/Pathology Services Exception (Ascension Network Provider). This exception applies if you:
  - Incur costs for services at an Ascension Network provider; and
  - Incur associated costs for radiology or pathology services (other than lab work) rendered by one or more National Network and/or Out-of-Network providers; and
  - Had no control over the selection of such provider(s).

- Radiology/Pathology Services Exception (National Network or Out-of-Network Provider). This exception applies if you:
  - Incur costs for services at a National Network or Out-of-Network provider with an EPO Approved Referral; and
  - Incur associated costs for radiology or pathology services (other than lab work) rendered by one or more National Network or Out-of-Network providers; and
  - Had no control over the selection of such provider(s).

Section 9: 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 via an EPO Approved Referral), 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 a request for an EPO Approved Referral 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 five 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.
- 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.

How 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/. After selecting **Member Resources**, go to the Appeal process section of **Additional Resources** and 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 *Your Contact Information* at the beginning of this SPD.

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 three days.

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

- A determination that the Plan will not pay the total amount of expenses other than Cost-Sharing amounts under the terms of the Plan.
- 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).

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.

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 appeals 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 three 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 four 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 four 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 five 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 five 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 one 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 one 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 one 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 10: 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 12* 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 11: 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 comer, 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.

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

Section 12: 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, the Participant 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).

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 due to the termination of employment or reduction of hours of the Eligible Associate, and a second qualifying event occurs within the initial 18-month period, the Qualified Beneficiary may be able to extend coverage further, but only up to a total of 36 months. The second qualifying event must occur while the Qualified Beneficiary has continuation coverage.

The Qualified Beneficiary 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, seven 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 (subject to the limited exception discussed below).
- 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 (subject to the limited exception discussed below).
- 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.

The following exceptions apply to the early termination events noted above:

- If you (i) elected to retire under the Ascension Voluntary Early Retirement Program (the "VERP") during the "2024 Window Period" (as defined in the VERP); (ii) timely elected COBRA continuation coverage under the Plan; and (iii) are receiving subsidized COBRA continuation coverage under the VERP as a result of such retirement, then your subsequent enrollment in Medicare Part A or B would not result in the early termination of your COBRA continuation coverage.
- If you become covered under another group health plan, your continuation coverage will 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 *Your 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, one 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 13: 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.

Section 14: 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 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 15: 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	**CSC-Lawyers Incorporating Service Company** 221 Bolivar Street Jefferson City, MO 65101 Service of legal process may also be made upon the Plan Administrator.
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 included in 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 the 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 Copays and similar charges. Except in certain limited circumstances, such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), if you receive services from a provider or facility that is not in the EPO Network, the Plan will not pay anything for those services and the cost of those services will not count towards any Copays, Annual Out-of-Pocket Maximum or similar accumulator.

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, Annual Out-of-Pocket Maximum or similar accumulator.

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. Except in certain limited circumstances, such as an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), if you receive services from a provider or facility that is not in the EPO Network, the Plan will not pay anything for those services and the cost of those services will not count towards any Copay, Annual Out-of-Pocket Maximum or similar accumulator.

Cosmetic Surgery

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

Cost-Share/Cost-Shares/Cost-Sharing

The amounts owed by the Participant outside of payment, if any, by the Plan, whether through Copays 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. The Plan will pay for services rendered by a National Network provider or an Out-of-Network provider only if there is an EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

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.

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 who became permanently and totally disabled while covered under the Plan prior to attaining 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 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" 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 not less than 12 months.

Durable Medical Equipment

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.

EPO

Exclusive Provider Organization, an option under the Plan pursuant to which the Plan (i) pays only for Medically Necessary covered treatments, services, supplies and other charges rendered by a provider or at a facility in the EPO Network or in connection with an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*), and (ii) does not pay for any other treatments, services, supplies and other charges.

EPO Network

A network consisting of Ascension Network providers and facilities and EPO Referred Providers.

EPO Approved Referral

A referral by an Ascension Network Physician to a National Network or Out-of-Network Physician or facility that has been approved by the Plan Administrator or its designee. The referral must meet the requirements summarized in *Section 8*.

EPO Referral Exception

An exception to the requirement to obtain an EPO Approved Referral. See "EPO Referral Exceptions" in *Section 8* for specific details.

EPO Referred Provider

A National Network or Out-of-Network provider or facility that provides services pursuant to an EPO Approved Referral. The referral must meet the requirements summarized in *Section 8*.

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 United States Food & Drug Administration.

Health Ministry

Any legal entity that is related to the Sponsor.

High Tech Radiology Procedure

Advanced procedures with a dose of radiation that require Prior Authorization. For additional information, go to https://www.mysmarthealth.org/, select **Member Resources** and then the **Prior Authorization** section of **Additional Resources**.

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 hours-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 (PAP)

A program that a pharmaceutical manufacturer offers to the public in which a consumer may reduce their out-of-pocket costs for prescription drugs through the use of coupons, discount cards, prepaid gift cards, manufacturer debit cards, or by other means. The value received from any such coupons, discount cards, prepaid gift cards, manufacturer debit card or other means does not apply to any Deductible, Coinsurance, Copay, Annual Out-of-Pocket Maximum or similar accumulator under the Plan.

Note: The pharmaceutical manufacturer may change or terminate their PAPs at any time during the year. If that happens, the Participant will pay the regular Copay for the applicable prescription drug based on the Plan option they elected.

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. The Plan will pay for services rendered by an Out-of-Network provider only if there is an EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

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 used by a Health Ministry of Ascension. The Plan will pay for services rendered by a National Network provider only if there is an EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits)*.

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 United States 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. The Plan will pay for services rendered by an Out-of-Network provider only if there is an EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

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 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 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. To review a complete and up-to-date list of services that require Prior Authorization, go to https://www.mysmarthealth.org/, select **Member Resources**, and then the **Prior Authorization** section of **Additional Resources**. For specific details, you can also click on "**Prior authorization code list"** in the **Prior Authorization** section or call ABS at **888-492-6811** to speak to a customer service representative.

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 hours-a-day, seven days-a-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. The Plan will pay for services rendered by a National Network provider or an Out-of-Network provider only if there is an EPO Approved Referral except in the case of an EPO Referral Exception (including a Medical Emergency or as otherwise listed on the *Schedule of Benefits*).

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.