Medical Summary Plan Description

Blue Cross Blue Shield Illinois
Church Plan — Sisters of Charity of Cincinnati
Effective January 1, 2024

Who to Contact With Questions

General		
Question	**Contact**	**Applicable MBO**
General questions about eligibility for benefits, enrollment and qualified life event change, etc.	Contact local HR	• Sisters of Charity of Cincinnati

Medical Benefits	
Question	**Contact**
Questions about your coverage	Medical Plan Customer Service Team Blue Cross Blue Shield of Illinois www.bcbsil.com/chi (866) 776-4244
Find network providers	Medical Plan Customer Service Team Blue Cross Blue Shield of Illinois www.bcbsil.com/chi (866) 776-4244
Pre-certification	Medical Plan Customer Service Team Blue Cross Blue Shield of Illinois (866) 776-4244

Prescription Benefits	
Question	**Contact**
General questions about prescription benefits	Capital Rx www.cap-rx.com (844) 306-6254
Prescription claims	Capital Rx www.cap-rx.com (844) 306-6254

Our Mission
As CommonSpirit Health, we make the healing presence of God known in our world by improving the health of the people we serve, especially those who are vulnerable, while we advance social justice for all.

Table of Contents

Medical Plan Introduction

In accordance with the heritage of its participating congregations, CommonSpirit Health emphasizes care of the whole person in body, mind, and spirit. This commitment is reflected not only in the care provided to the individuals and communities CommonSpirit Health serves, but also in the Benefits the organization provides to you, its Employees.

The CommonSpirit Health Medical Plan (hereinafter referred to as the "Plan" or "Medical Plan") will be administered by Blue Cross Blue Shield of Illinois and the Pharmacy benefit will be administered by Capital Rx.

The Plan has been established on a self-insured basis; all liability for payment of Benefits is assumed by CommonSpirit Health. While Blue Cross Blue Shield of Illinois and Capital Rx administer payment of Claims, Blue Cross Blue Shield of Illinois and Capital Rx have no liability for the funding of the Benefit plan.

While one of the functions of Blue Cross Blue Shield of Illinois and Capital Rx is to process Claims according to the Plan provisions, all Claims paid under the Plan are paid by CommonSpirit Health and CommonSpirit Health owns the Claim files. Therefore, the final decision on any disputed Claim may involve review of these files by CommonSpirit Health.

The Plan was established on January 1, 2001, and this Summary Plan Description ("SPD"), which provides detailed descriptions of the Benefits available to you, is revised as of January 1, 2024. This Summary Plan Description replaces all Summary Plan Descriptions and related amendments effective prior to January 1, 2024, relative to the Plan and shall remain in effect until further notice. Please read the information in this Summary Plan Description carefully so you will have a full understanding of your health care Benefits. If you want more information or have any questions about your health care Benefits, please contact the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card.

A copy of this SPD is available online at https://www.chibenefitplans.net.

Important Information

CommonSpirit Health reserves the right to amend, modify or terminate the Plan, in whole or in part, at any time for any reason. The Plan is a component program of the CommonSpirit Health ERISA Welfare Benefit Plan (the "Wrap Plan"). This Summary Plan Description in conjunction with the Wrap Plan constitute the formal Plan document as required under ERISA.

Nothing in the Plan or this Summary Plan Description constitute or may be construed as a contract, promise, or other arrangement of continued employment.

Charts and Call-Out Boxes

Some sections of this SPD have charts and/or call-out boxes, which provide a quick reference or summary, but they are not a complete description of all details about a topic. A particular chart or call- out box may not describe some significant factors that would help determine your benefits, payments, or other responsibilities. Where examples are given, the dollar amounts provided are strictly to help you understand the concept and are not intended to reflect the actual or typical cost for such a service.

It is important for you to learn about all of the details of a topic and follow any references to other sections of the SPD. (References tell you to "see" a section or subject heading, such as, "see The Details — What's Covered and Not Covered." References may also include a page number.)

Complete Information

Very often, complete information on a subject requires you to consult more than one section of the Summary Plan Description. For your convenience we have included a Glossary of Terms that defines the meanings of words found throughout this Summary Plan Description that are written in capital letters and have very specific meanings.

Most information on Benefits will be found in these sections:

- Highlights of the Medical Plan Options
- Quick Reference — What's Covered and Not Covered
- The Details — What's Covered and Not Covered
- General Conditions of Coverage, Exclusions, and Limitations

However, Benefits might also be affected by your choice of Provider (see Network Details — Choosing a Provider), certain notification requirements (see Medical and Pharmacy Notification Requirements and Care Coordination), and considerations of eligibility (see Adding or Dropping Coverage).

Even if a service is listed as covered, Benefits might not be available in certain situations, and even if a service is not specifically described as being excluded, it might not be covered.

You can use your Medical Plan to your best advantage by learning how this SPD is organized and how sections are related to each other. Whenever you look up a particular topic, be sure to follow any references and read thoroughly.

Highlights of the Medical Plan Option

This chart summarizes your Benefit options and payment responsibilities. It is only intended to provide you with an overview. It is important that you also read The Details — What's Covered and Not Covered section of this Summary Plan Description and not just rely on this chart for your Benefits coverage information.

Note: Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate.

*When the No Surprises Act applies, the amount you pay will be determined in accordance with the No Surprises Act and you will not be billed for more than the amount you would pay if the services had been provided by an In-Network Provider. The No Surprises Act typically applies to Emergency Services (including certain post-stabilization services) at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at In-Network facilities, and air ambulance services.

A Snapshot of the Medical Plan

<table>
<tr><th></th><th>Standard Health Plan</th><th>Standard HDHP</th></tr>
<tr><td></td><td>You Pay</td><td>You Pay</td></tr>
<tr><td colspan="3">Annual Deductible[1]</td></tr>
<tr><td>CommonSpirit Facility</td><td>$0</td><td rowspan="2">$3,200 individual / $6,400 family</td></tr>
<tr><td>BC/BS PPO Network</td><td>$1,750 individual / $3,500 family</td></tr>
<tr><td>Out-of-Network</td><td>$3,500 individual / $7,000 family</td><td>$6,000 individual / $12,000 family</td></tr>
<tr><td colspan="3">Annual Out-of-Pocket Maximum[2]</td></tr>
<tr><td>CommonSpirit Facility</td><td rowspan="2">$3,750 individual /$7,500 family</td><td>$5,000 individual /</td></tr>
<tr><td>BC/BS PPO Network</td><td>$10,000 family</td></tr>
<tr><td>Out-of-Network</td><td>$12,000 individual /$24,000 family</td><td>$12,000 individual /$24,000 family</td></tr>
</table>

[1]There are individual Deductibles embedded within the family Deductible.

[2]The In-Network Out-of-Pocket Maximum includes Prescription Drug Copayments and Coinsurance but the Out-of-Pocket Maximum overall does not include penalties or ineligible charges. There are individual Out-of-Pocket Maximums embedded within the family Out-of-Pocket Maximum, and all cease once the family Out-of-Pocket Maximum is met for the calendar year.

Summary of Benefits

	Standard Health Plan	Standard HDHP
	Plan Pays	Plan Pays
Once you satisfy the annual Deductible, the plan will pay the coinsurance percentage listed below until you reach the out-of-pocket maximum. In some circumstances, you are responsible for paying a copayment before the plan will pay the coinsurance.		
Preventive Care CommonSpirit Facility BC/BS PPO Network Out-of-Network	100% Covered	100% Covered
Office Visits*:Primary Care CommonSpirit Facility	Not Applicable	Not Applicable
BC/BS PPO Network	75% No Deductible	80% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Office Visits*: Specialist CommonSpirit Facility	Not Applicable	Not Applicable
BC/BS PPO Network	70% No Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Office Visits: Mental Health CommonSpirit Facility	Not Applicable	Not Applicable
BC/BS Network	75% No Deductible	80% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Urgent Care CommonSpirit Facility BC/BS PPO Network Out-of-Network	100% after $75 Copay; No Deductible	100% after $75 Copay After Deductible
Emergency Room CommonSpirit Facility BC/BS PPO Network Out-of-Network	100% after $200 Copay, Copay waived if admitted	$200 Copay after Deductible, Copay waived if admitted
Non-emergency Use of Emergency Room CommonSpirit Facility BC/BS PPO Network Out-of-Network	50% After Deductible (no Deductible if CommonSpirit facility)	50% After Deductible
Ambulance** (air, ground or water) – must be Medically Necessary CommonSpirit Facility BC/BS PPO Network Out-of-Network	100% Covered	100% Covered After Deductible
Inpatient Care/Services CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Outpatient Care/Services CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible

*Related services billed with an office visit are paid at the applicable office visit benefit level. The annual Deductible and applicable coinsurance amount will apply to related services billed separately from the office visit.

**Most ambulance services are out of network.

Summary of Benefits Continued

	Standard Health Plan	Standard HDHP
	Plan Pays	Plan Pays
Once you satisfy the annual Deductible, the plan will pay the coinsurance percentage listed below until you reach the Out-of-Pocket maximum. In some circumstances, you are responsible for paying a copayment before the plan will pay the coinsurance.		
Physical, Speech & Occupational Therapy (30 visit maximum for all therapies combined per person per Benefit Year) CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form, not subject to maximum	85% After Deductible; for FACILITY charges billed on UB form, not subject to maximum
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Durable Medical Equipment CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Inpatient Mental Health and Chemical Dependency CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% No Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Outpatient Mental Health and Chemical Dependency CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% No Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Other Covered Services CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Fertility Treatments ($15,000 lifetime maximum per person; $5,000 lifetime maximum on fertility drugs per person) CommonSpirit Facility (For Benefit Information, see The Details — What's Covered and Not Covered on page 36)	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Chiropractic Care (20 visit maximum per person per Benefit Year) CommonSpirit Facility	85% No Deductible for FACILITY charges billed on UB form	85% After Deductible for FACILITY charges billed on UB form
BC/BS PPO Network	70% After Deductible	75% After Deductible
Out-of-Network	40% After Deductible	40% After Deductible
Lifetime Maximum	Unlimited	Unlimited

Pharmacy Summary of Benefits

Covered prescription expenses will apply toward the medical in-network Out-of-Pocket Maximum. Once the medical in-network Out-of-Pocket Maximum is met, your covered prescriptions will be 100 percent covered by the plan.

	Standard Health Plan		Standard HDHP	
	Plan Pays		Plan Pays	
	In-Network	Out-of-Network	In-Network	Out-of-Network
CommonSpirit Pharmacy, if available (30-Day Prescriptions)				
Generic Drugs	100% after $5 Copayment No Deductible	N/A	100% after $5 Copayment and After Deductible	N/A
Preferred Brand-name drug on formulary	85% ($20 min/$55 max) No Deductible	N/A	85% ($20 min/$55 max) After Deductible	N/A
Non Preferred Brand-name drug not on formulary	75% ($32.50 min/$80 max) No Deductible	N/A	75% ($32.50 min/$80 max) After Deductible	N/A
Capital Rx Retail Pharmacy (30-Day Prescriptions)				
Generic Drugs	100% after $10 Copayment No Deductible	40% No Deductible	100% after $10 Copayment and After Deductible	40% After Deductible
Preferred Brand-name drug on formulary	70% ($40 min/$110 max) No Deductible	40% No Deductible	70% ($40 min/$110 max) After Deductible	40% After Deductible
Non Preferred Brand-name drug not on formulary	50% ($65 min/$160 max) No Deductible	40% No Deductible	50% ($65 min/$160 max) After Deductible	40% After Deductible
CommonSpirit Home Delivery, If Available (90-Day Prescription)				
Generic Drugs	100% after $12.50 Copayment No Deductible	N/A	100% after $12.50 Copayment and After Deductible	N/A
Preferred Brand-name drug on formulary	85% ($50 min/$87.50 max) No Deductible	N/A	85% ($50 min/$87.50 max) After Deductible	N/A
Non Preferred Brand-name drug not on formulary	75% ($80 min/$162.50 max) No Deductible	N/A	75% ($80 min/$162.50 max) After Deductible	N/A
Optum Home Delivery (90-Day Prescription)*, **				
Generic Drugs	100% after $25 Copayment No Deductible	N/A	100% after $25 Copayment and After Deductible	N/A
Preferred Brand-name drug on formulary	70% ($100 min/$175 max) No Deductible	N/A	70% ($100 min/$175 max) After Deductible	N/A
Non Preferred Brand-name drug not on formulary	50% ($160 min/$325 max) No Deductible	N/A	50% ($160 min/$325 max) After Deductible	N/A

Note: If you fill a brand-name prescription when there is a generic equivalent available, you will pay the applicable tier brand-name prescription Coinsurance plus the difference between the generic and brand- name amount. If it is Medically Necessary for you to have the brand-name prescription, your doctor can contact the CommonSpirit prescription administrator to get an exception so you don't have to pay the difference between the generic and the brand-name amount. You will pay the brand-name prescription Coinsurance.

All maintenance medications will be filled through CommonSpirit Pharmacy or Optum Home Delivery.

Specialty prescriptions must be processed through the CommonSpirit Specialty Pharmacy. If the CommonSpirit Specialty can't fill your specialty medication, your prescription will be routed to a Capital Rx Specialty Pharmacy partner.

Quick Reference — What's Covered and Not Covered

Your coverage provides Benefits for many services and supplies. There are also services for which this coverage does not provide Benefits. The following chart is provided for your convenience as a **quick reference only**. This chart is not intended to be and does not constitute a complete description of all Benefits coverage details and factors that determine whether a service is covered or not. All Covered Services are subject to the contract terms and conditions contained throughout this Summary Plan Description. Many of these terms and conditions are contained in The Details — What's Covered and Not Covered. To fully understand which services are covered and which services are not, you must become familiar with this entire Summary Plan Description. If you are unsure whether a particular service is covered or not, please contact the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card.

The chart on the following page provides the following information:

Category – Service categories are listed alphabetically and are repeated, with additional detailed information, in The Details — What's Covered and Not Covered.

Covered – The listed category is generally covered, but some restrictions may apply.

Not Covered – The listed category is generally not covered.

See page – This column lists the page number in The Details — What's Covered and Not Covered where there is further information about the category.

Service/Prescription Maximums and Limitations – This column lists maximum Benefit amounts that each Plan Participant is eligible to receive per Covered Service, prescription, Benefit Plan Year, or a Lifetime Maximum. Service maximums or prescription maximums that apply per Benefit Year or per Lifetime Maximum are reached from Claim Payment amounts accumulated under this Plan and any prior group health plans sponsored by CommonSpirit Health.

Notification Required – This column indicates categories of care that may require pre-notification of treatment or pre-authorization for the purchase of Prescription Drugs. If there is nothing in this column for a particular type of service, it means that it is not necessary to provide pre-notification of the treatment or obtain pre-authorization to purchase a Prescription Drug.

Quick Reference - What's Covered and Not Covered

Category	Covered	Not Covered	Page	Maximums and Limitations†	Notification Required‡
Abortions - non-life threatening		Ø	28		
Acupuncture	•		28	10 visits per person per Benefit Year	
Allergy Testing and Treatment	•		28		
Ambulance Transportation	•		29		
Ambulatory Surgical Facilities	•		29		
Anesthesia Services	•		29		
Applied Behavior Analysis (ABA) Therapy	•		29		
Assistant Surgeons	•		30		
Blood and Blood Administration	•		30		
Cardiac Rehabilitation Service	•		30		
Chemotherapy Treatments	•		30		
Chiropractic Care	•		30	20 visits per person per Benefit Year	
Completion of Claim Forms, Reports, or Medical Records		Ø	31		
Complications of Non-Covered Services/Treatments		Ø	31		
Consultations	•		31		
Contraceptives	•	Ø	31	Coverage depends on whether you are from a profit or non-profit part of CommonSpirit Health. If not covered through the Medical Plan, you may have coverage directly through the medical and/or prescription administrators	
Cosmetic Surgery - elective		Ø	31		
Cosmetic Surgery - reconstructive	•		31		Prior Approval Recommended
COVID-19 Testing and Treatment	•		32	Coverage for Medically Necessary diagnostic and serological testing and treatment. Includes, but not limited to telehealth/telemedicine, virtual office visit, and audio-only office visits.	
Custodial Care Services		Ø	32		
Cyber Knife Surgery	•		32		
Dental Services - special circumstances	•		32	Limitations apply	
Dental Services - standard		Ø	32		
Diabetes Training Programs	•		33		

Category	Covered	Not Covered	Page	Maximums and Limitations†	Notification Required‡
Diagnostic Services	•		33		
Digital Breast Tomosynthesis (3D Mammography)	•		33		
Durable Medical Equipment	•		33		Prior Approval Recommended
Educational or Training Programs		Ø	34		
Eligible Charges for Multiple Surgical Procedures	•		34		
Emergency Services	•		34		
Eye Examinations - Medical Conditions	•		34		
Eye Examinations - Vision		Ø	34		
Eyeglasses and Cosmetic Contacts		Ø	35		
Eyeglasses or Contacts - after cataract surgery or cornea transplant	•		35	First pair only	
Failure to Keep a Scheduled Appointment		Ø	35		
Family Members Who Provide Services		Ø	35		
Fertility Drugs	•		35	Lifetime maximum of $5,000 per person	
Fertility Treatment	•		35	Lifetime maximum $15,000 for identified covered services per covered individual	Prior Approval Recommended
Foot Care	•		36		
Foot Orthotics	•		36	Two pairs per Benefit Year	
Gender Affirmation Treatment	•		36		
Genetic Testing	•		36		May be required
Hearing Aids		Ø	36		
Hearing Examinations for Diagnosing Medical Conditions	•		36		
Hearing Examinations for Pure Tone Audiometry Tests		Ø	36		
Home Health Care	•		36		•
Hospice Care	•		37	Life expectancy must be 12 months or less	•

Category	Covered	Not Covered	Page	Maximums and Limitations†	Notification Required‡
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary		Ø	38		
Human Organ Transplants	•		38	Cryopreservation and storage $10,000 limit per transplant	•
Inpatient Hospital Care	•		40		•
Kerato-Refractive Eye Surgery		Ø	41		
Leg, Back, and Neck Braces	•		41		
Marriage Counseling	•		41		
Massage Therapy		Ø	41		
Mastectomy and Related Services	•		41		
Maternity Services	•		42		•
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes	•		42		
Mental Health Services - Inpatient	•		42		•
Mental Health Services - Outpatient	•		42		
Modifications to Homes, Property, or Automobiles		Ø	43		
Nephropathy screenings	•		43	Covered 100% for diabetic members	
Non-Emergency Use of the Emergency Room	•		43		
Non-Prescription Drug Medication (except Medically Necessary B-12 injections)		Ø	43		
Occupational Therapy	•		44	Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits	
Office Visits	•		44		
“-ologists” at In-Network and CommonSpirit Facilities	•		45		
Optometry Services - routine		Ø	45		
Outpatient Hospital Care	•		44		
Oxygen and its Administration	•		45		
Personal Hygiene, Comfort, and Convenience Items		Ø	45		
Physical Therapy	•		46	Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits	

Category	Covered	Not Covered	Page	Maximums and Limitations†	Notification Required‡
Physicians	•		46		
Pre-Admission Testing	•		47		
Prescription Drugs	•		47		May be required
Prescription Drugs - targeted for step therapy	•		47		•
Preventive or Wellness Care	•		48		
Prosthetic Appliances and Devices	•		49		Prior Approval Recommended
Radiation Therapy Treatments	•		49		
Residential Treatment Facilities - Diagnostic tests	•		49		
Residential Treatment Facilities - room and board	•		49		•
Retinal Eye Exams	•		49	Covered 100% for diabetic members	
Routine Physical Exams	•		50		
Self Help Programs		Ø	50		
Shock Therapy Treatments	•		50		
Skilled Nursing Facilities	•		50		•
Sleep Apnea Treatment	•		50		
Smoking/Tobacco Cessation Prescription Drugs	•		51		
Speech Therapy	•		51	Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits	
Sterilization Procedures		Ø	51		
Sterilization Reversals	•		51		
Substance Use Disorder Treatment	•		51		•
Surgery	•		52		
Telehealth Services	•		52		
Temporomandibular Joint Dysfunction and Related Disorders	•		52	Non-surgical treatment of TMJ is not covered by the Medical Plan but is covered by the dental plan.	
Web Cam Consultations	•		53		
Weight Loss Prescription Drugs		Ø	53		
Weight Loss Surgery	•		54	Limit one per lifetime with allowance for adjustments	•

Category	Covered	Not Covered	Page	Maximums and Limitations†	Notification Required‡
Wigs or Hair Pieces - if hair loss from medical treatment	•		54	1 wig per year	
Wilderness Program		Ø	55		
X-Ray and Laboratory Services	•		55		

†If nothing is listed in this column, assume there are no limitations or maximums; however, Benefits will not be available if the procedure is not Medically Necessary or not for a Covered Service.

‡If nothing is listed in this column, assume that prior notification is not required.

Adding or Dropping Coverage

This SPD contains information about the Plan for persons who meet the definition of an Eligible Person as determined by CommonSpirit Health and defined in the Glossary of Terms found in the back of this SPD. The Glossary of Terms includes the eligibility requirements for you and your Dependents. Please see the definitions of Employee, Spouse, Legally Domiciled Adult and Child.

Please refer to the Eligibility Addendum of this SPD for a description of eligibility at each CommonSpirit Health Market-Based Organization (MBO) or facility. If you meet the description of an Eligible Person and have applied for coverage under this Plan, then you are entitled to the Benefits described in this SPD as of your Coverage Date.

Eligibility

Each Employee of an Employer (i.e., CommonSpirit Health and the MBOs listed in the Eligibility Addendum) who has satisfied the applicable "regularly scheduled hour" requirement and waiting period listed in the Eligibility Addendum (i.e., an Eligible Person) is eligible for coverage under this Plan if such Eligible Person enrolls for coverage and pays any required premium contributions in accordance with applicable procedures established by the Employer. Your coverage under the Plan will end as of the end of the month during which you cease to be an Eligible Person. An Eligible Person may also enroll his or her Dependent(s) for coverage under this Plan in accordance with applicable procedures established by the Employer. Coverage under the Plan for your Dependent(s) will end as of the end of the month during which such Dependent(s) cease to be Dependent(s).

Your Coverage

As an Employee of CommonSpirit Health, you must meet the requirements of your MBO as described in the Eligibility Addendum in this SPD.

You may enroll in Individual Coverage or Family Coverage. If you choose to enroll yourself in Individual Coverage, only your own health care expenses, not the health care expenses of your other family members, are covered according to the Benefit levels in this SPD. If you enroll in Family Coverage, your expenses for Covered Services and those of your enrolled Spouse or Legally Domiciled Adult and/or Child(ren) will be covered according to the Benefit levels of this SPD.

Please refer to the definitions of Spouse, Legally Domiciled Adult and Child found in the Glossary of Terms section of this SPD to determine who qualifies as a Dependent under this Plan.

Your Dependent's Coverage

Dependents eligible for the Medical Plan include:

- An Eligible Person's Spouse who is legally married to the Eligible Person or an Eligible Person's Legally Domiciled Adult who is over age 18 and has, for at least six months, lived in the same principal residence of an Employee and remains a member of that Employee's household throughout the coverage period; and who either:
    - Has an on-going, exclusive and committed relationship with the Employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the Employee, is neither legally married to anyone else nor legally related to the Employee by blood in any way that would prohibit marriage or
    - Is the Employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period and is not considered a Child as defined in this section of the Summary Plan Description.
- An Eligible Person's Child, married or unmarried, by birth, marriage, legal adoption or placement for adoption who is under age 26.
- A Child under age 26, married or unmarried, whom you are required by law to provide health coverage or the Eligible Person is the Legal Guardian, such as a court-approved foster Child.
- A Child under age 26, married or unmarried, of an eligible Legally Domiciled Adult.
- An Eligible Person's unmarried Child by birth, marriage, legal adoption or placement for adoption who is age 26 or older, who is dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began prior to the date the Dependent attained age 26 and:
    - The disabled Dependent was covered by this Plan or other group medical insurance coverage as a disabled Dependent prior to reaching age 26.
    - If enrolling for the first time, the disabled Dependent who is 26 years of age or older of a newly Eligible Person may be enrolled for coverage if the Eligible Person enrolls during the initial eligibility period

and provides proof that the Dependent satisfies the foregoing requirements within 31 days of the initial date of eligibility.

The Plan may request documentation of the Dependent's continued disability on an annual basis. If the recertification documentation is not completed or the dependent is determined ineligible, the disabled Dependent will be subject to termination from the Plan. If the appropriate documentation is received within the timeline outlined within the letter and the documentation proves the dependent is still disabled, the disabled Dependent shall be eligible for coverage so long as the Dependent continues to be disabled, unless coverage otherwise terminates under the Plan. The disabled Dependent must be continuously covered under the Plan in order to maintain eligibility.

Dependent Eligibility Audit

To be good stewards of our resources and continue to provide affordable, high-quality benefits to Employees and their families, CommonSpirit Health verifies the eligibility of our Employees' Dependent(s) enrolled in any of the following plans:

- Medical Plan
- Dental Plan
- Vision Plan

When a Dependent is added to one of these plans, the Employee will receive an audit notice and must return the appropriate documentation by the due date or the Dependent(s) will lose coverage. If the Employee does not respond to the audit or provide appropriate information, the dependent will be dropped from the plan. Re-enrollment for the following plan year or via a Qualifying Life Event, will not be allowed until the completed dependent verification documentation is received and approved.

CommonSpirit Health reserves the right to request verification of Dependent status at any time and may pursue any fraudulent activity.

Pre-existing Conditions Waiting Period

The Medical Plan **does not** have a pre-existing Conditions waiting period. You will be entitled to the Benefits described in this Summary Plan Description as of your Coverage Date.

Enrolling in Benefits

Initial Enrollment

You must enroll yourself and your eligible Dependents in your benefits within 31 days of the new hire or newly eligible date. If you do not enroll within the initial 31-day enrollment period, you will have to wait until the next Annual Benefit Enrollment period to enroll, unless you experience a Qualified Life Event (see Eligible Reasons and Time Limits to Add Coverage During the Year Due to a Qualified Life Event section).

Late Enrollment

If you enroll in the Plan within the eligible enrollment timeframe, your benefit elections will remain in effect throughout the year. If you do not meet the enrollment deadline, you won't be eligible to elect coverage (unless you experience a Qualified Life Event or until Annual Benefit Enrollment - typically held in the fall).

Enrollment Process

An Eligible Person enrolls in the Medical Plan by completing the enrollment process established for or by the MBO. When enrolling in your coverage you will elect the type of coverage you desire and will indicate which of your eligible Dependents you wish to enroll in the Plan. You must provide the Social Security number of each person enrolling in the Medical Plan, as required by the Patient Protection and Affordable Care Act.

Type of coverage includes:

- Employee Only
- Employee + Spouse/Legally Domiciled Adult
- Employee + Child(ren)
- Family (includes either a Spouse or Legally Domiciled Adult, and Children)

Identification Numbers Required

You must provide the Social Security number (SSN) of each person enrolling in the Medical Plan, as required by the Patient Protection and Affordable Care Act. SSNs or Individual Taxpayer Identification Numbers (ITINs) are required for enrollment of all Eligible Dependents. Failure to provide the dependent SSN, will result in termination of that dependent's benefit eligibility. There are, however, three exceptions to this rule:

1. If your Eligible Dependent is a newborn baby, you have until the child's first birthday to produce the child's SSN/ITIN.
2. If your Eligible Dependent is an adopted child, you have one year from the date your child was placed with you for adoption to provide the child's SSN/ITIN*.
3. If your Eligible Dependent does not have an SSN/ITIN*.

*If you enroll your Eligible Dependent without providing an SSN/ITIN, based on exceptions number 2 or number 3, you must complete the Dependent SSN/ITIN Requirement form (or similar form) when requested. The CommonSpirit Health Benefits Contact Center will provide you with a Dependent SSN/ITIN Requirement form to complete upon request. The form releases the Plan for any losses that occur, related to inaccurate or incomplete SNN/ITIN information on your dependent.

Your Cost of Coverage

If elected, you and CommonSpirit Health share in the cost of medical/prescription drug coverage. Your contributions will be deducted from your paycheck on a before-tax basis.

Eligible Reasons and Time Limits to Add Coverage During the Year Due to a Qualified Life Event

You should enroll as soon as possible, but enrollment must be completed within the following time limits:

- The initial enrollment must be completed within the initial 31-day enrollment period.
- If you have a new Dependent as a result of a birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, you can enroll your Dependent within 60 days of that Qualified Life Event.
- If you have a new Dependent as a result of a marriage, you can enroll your Dependent within 31 days of that Qualified Life Event.
- If you declined enrollment for yourself and/or your Dependents because of other health insurance coverage, you can enroll yourself and/or your Dependents during the year if you and/or your Dependents lose eligibility for that coverage. You must request enrollment for yourself or a Dependent within 31 calendar days after your other coverage ends.
- If you declined enrollment for yourself and/or your Dependents because of other health insurance coverage and another employer stops contributing to that coverage, you can enroll yourself and/or your Dependents during the year. However, you must request enrollment for yourself or a Dependent within 31 calendar days after the other employer stops contributing toward the other coverage.
- An Eligible Person or Dependent may also enroll in the Plan within 31 days of a life event or Qualified Life Event, such as marriage, if such enrollment is consistent with the change in status.
- If you and/or your Dependent either lose eligibility for a Medicaid or state Child Health Insurance Program (state CHIP), or gain eligibility for Medicaid or state CHIP premium assistance program that pays part of the cost of coverage for you and/or your Child, you must enroll you and/or your Child within 60 days of the date of eligibility or loss of coverage under the government program.

If you add a Dependent as a result of a Qualified Life Event, the coverage will be effective the first of the month following your notification of the event to CommonSpirit Health, unless the change and notification coincides with the first of the current month. However, if the change is due to a birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, the coverage will be effective as of the event date of the Qualified Life Event. For birth, adoption, obtaining Legal Guardianship, or interim court order prior to finalization of adoption, you will be responsible for any back premiums.

Important Timing for Enrolling Your Newborn

You must enroll your newborn in the Plan within 60 days of the date of birth.
All charges for the newborn inpatient stay (both facility and professional charges) while the mother is in the hospital (or beyond the mother's discharge date) will not be covered under the Plan until the newborn Child is added to the Plan. If the newborn Child is not added within 60 days, the Child will not be eligible for coverage until the next Annual Benefit Enrollment, even if you already have Family Coverage. The Child must meet the definition of a Dependent as defined in the Glossary of Terms in this SPD in order to be enrolled in this Plan.

Time Limits for Changing or Dropping Your Coverage Due to a Qualified Life Event

- If an enrolled Dependent loses his or her eligibility as a Dependent for any reason, including but not limited to a divorce, legal separation, annulment, ceasing to be within the age limits or the death of a Dependent, you must remove that Dependent within 31 days of the Qualified Life Event or within 31 days of the date coverage is to terminate, whichever is later.
- If you or an enrolled Dependent becomes eligible for coverage under another Plan, you may drop this coverage within 31 days of becoming eligible for that plan.
- If you or an enrolled Dependent enroll in a medical plan option available through the Exchange, you may drop this coverage within 31 days of enrolling in the Exchange.
- If you or your Dependent Child become eligible for coverage under Medicaid or state CHIP, you may drop this coverage within 60 days of becoming eligible for Medicaid or state CHIP.

If you choose to add or drop coverage due to a birth, adoption, or placement for adoption, your benefit changes will take effect retroactively back to the date of the birth, adoption, or placement for adoption, provided that you timely notify [the Plan] of the event. Otherwise, changes resulting from any other Qualified Life Event will be effective as follows:

- If you choose to add coverage, the first day of the month coincident with or following the date that you provide notification of the Qualified Life Event and resulting election change to [the Plan]. For example: your marriage takes place on December 29th. You notify [the Plan] of your election to add your newly Eligible Dependent(s) on January 5th. The effective date of coverage for the newly added Eligible Dependent(s) will be February 1st (the first day of the month following the date of notification).

- If you choose to drop coverage for yourself and/or an otherwise eligible enrolled Dependent because of a Qualified Life Event, that coverage will terminate at the end of the month during which [the Plan] receives notification from you of the election to drop coverage. Premiums will cease as of the end of the month in which coverage terminates. For example: your Spouse gains benefit coverage through his/her employer on October 15th. The Spouse's coverage will be dropped effective November 1st, provided you make the election change no later than October 31st. Notwithstanding the above, if, as a result of a Qualified Life Event, your enrolled Dependent ceases to be eligible under the Plan, then coverage will terminate at the end of the month during which the Qualified Life Event occurred, regardless of when you provide notice to [the Plan] of that event. To the extent you fail to provide timely notice to [the Plan] that an enrolled Dependent is no longer eligible under the Plan due to a Qualified Life Event, [the Plan Administrator] reserves the right to terminate such Dependent's coverage retroactive to the date that individual was no longer eligible for coverage under the Plan. In no instance will the Plan be obligated to pay a Claim for an ineligible Person, even if you are paying a higher premium because the Dependent was not dropped within the proper time frame or was covered but was not eligible for such coverage.

Qualifying Life Events for Changing Your Coverage

Change in legal marital status

Must notify Plan within 31 days

- Marriage (Spouse becomes eligible for this Plan)
- Divorce (Spouse is no longer eligible for coverage under this Plan)
- Legal Separation (Spouse is no longer eligible for coverage under this Plan)
- Annulment (Spouse is no longer eligible for coverage under this Plan)
- Death of a Spouse

Change in number of Dependents

Must notify Plan within 60 days

- Birth, Adoption, Placement for adoption
- Obtaining legal custody of a child
- Child gains or loses eligibility for Medicaid or state Children's Health Insurance Program (CHIP)

Must notify Plan within 31 days

- Marriage resulting in gaining step-children
- Obtaining legal guardianship or court approved foster care of a child
- Child age 26 or over is approved for continuous coverage due to a continuous developmental or physical disability that began while the child was covered under this Plan or other group medical insurance coverage (coverage must be continuous since the inception of the child's disability)
- A Qualified Medical Child Support Order (QMCSO) goes into effect
- Death
- Divorce resulting in loss of step-children
- Losing legal guardianship or court approved foster care of a child
- Losing legal custody of a child
- A child reaches the maximum age under the Plan
- A Qualified Medical Child Support Order (QMCSO) is terminated

Change in Employment Status of you or your Spouse

Must notify Plan within 31 days

- Termination of employment
- Gaining employment
- Strike or lockout
- Beginning an unpaid leave of absence that affects an Employee's eligibility under the Plan
- Ending an unpaid leave of absence that affects an Employee's eligibility under the Plan
- Change in worksite that results in different plan options
- Change in employment status affecting eligibility for Benefits

Other Qualified Life Events

Must notify Plan within 31 days

- Group plan you were enrolled in or were eligible for through another employer or group has a material and substantive change making it significantly more or less attractive to you
- The group plan you or your eligible Dependents were enrolled in was terminated
- Gaining or losing eligibility for Medicare or COBRA
- Your Legally Domiciled Adult who was not eligible before becomes eligible under the eligibility affidavit guidelines.
- Your Legally Domiciled Adult no longer meets the eligibility criteria listed in the eligibility affidavit

Consistency Rule

An election change must be due to and consistent with the Qualified Life Event that affects eligibility for coverage under this Plan.

For example, you would not be permitted to add a Child from your prior marriage who was not previously covered under this Plan just because you re-married. However, you would be permitted to add your new Spouse and stepchildren as a result of that marriage if you enroll them within 31 days of the date of your marriage.

Reinstatement of Coverage

Notwithstanding anything in this Plan to the contrary, if you experience a Qualified Life Event or Special Enrollment Event that allows or requires that you be reinstated in coverage in the Plan, your coverage will become effective in accordance with applicable law.

Qualified Medical Child Support Orders

The term "qualified medical child support order" means a qualified medical child support order within the meaning of ERISA Section 609 which is a medical child support order which creates or recognizes the existence of an alternate recipient's right to, or assigns to an alternate recipient the right to, receive benefits for which a participant or beneficiary is eligible under the Plan provided that such medical support order clearly specifies:

- The name and last known mailing address (if any) of the participant and the name and mailing address of each alternate recipient covered by the order, except that, to the extent provided in the order, the name and mailing address of an official of a state or political subdivision thereof may be substituted for the mailing address of any such alternate recipient,
- A reasonable description of the type of coverage to be provided to each such alternate recipient, or in the manner in which such type of coverage is to be determined, and
- The period to which such order applies and does not require a plan to 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 [42 USC § 1396g] (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993). The term "medical child support order" means any judgment, decree, or order (including approval of a settlement agreement) which
    - Provides for child support with respect to a child of a participant under this Plan, and provides for health benefit coverage to such a child, is made pursuant to a state domestic relations law (including a community property law), and relates to benefits under this Plan; or
    - Is made pursuant to a law relating to medical child support described in section 1908 of the Social Security Act [42 USC § 1396g] (as added by section 13822 of the Omnibus Budget Reconciliation Act of 1993) with respect to a group health plan, if such judgment, decree, or order is issued by a court of competent jurisdiction or is issued through an administrative process established under state law and has the force and effect of law under applicable state law. For purposes of this subparagraph, an administrative notice which is issued pursuant to an administrative process referred to in the preceding sentence and which has the effect of a court order shall be treated as such an order.

The term "alternate recipient" means any child of a participant who is recognized under a medical child support order as having a right to enrollment under a group health plan with respect to such participant.

Dual Coverage Under This Plan is Prohibited

No person will be covered as a Dependent of more than one Employee, and no person will be covered as both an Employee and a Dependent.

Changes in the Employment Status of You or Your Spouse/Legally Domiciled Adult That Will Affect Your Enrollment in This Plan

If you become eligible for this Plan as a result of a change in Employment Status, you may enroll in this Plan within 31 days of your change in Employment Status.

If you lose eligibility for this Plan, your coverage will automatically be terminated at the end of the month in which you become ineligible for this coverage due to a change in your Employment Status.

If you or your Dependents enroll in coverage because your Spouse/Legally Domiciled Adult loses eligibility for coverage through his or her employer due to a change in Employment Status, you and your Dependents may enroll in this Plan within 31 days of the date that your Spouse/Legally Domiciled Adult loses coverage through his or her employer. However, coverage through the other plan must not have been terminated for failure to pay premiums or for fraudulent cause.

If you or your Dependents drop coverage because your Spouse/Legally Domiciled Adult enrolls in coverage through his or her employer due to a change in Employment Status, you and your Dependents may drop this Plan within 31 days of the date that your Spouse/Legally Domiciled Adult enrolls in coverage through his or her employer.

Your ID Card

After enrolling in the Plan, you will receive a Medical Plan ID Card. This card includes your member identification number and will be very important to you in obtaining Benefits for Medical Care and Prescription Drugs. You will receive one ID card if you have Single Coverage and you will receive two ID cards if you have Family Coverage. Both ID cards will show your name. If you need additional ID cards, please call the Medical Plan Customer Service Team at the number on the back of your ID card to request them.

Medicare Eligible Persons and Their Enrollment in This Plan

If you meet the definition of an Eligible Person found in the Glossary of Terms section of this Summary Plan Description, and you are eligible for Medicare, and not affected by the Medicare Secondary Payer (MSP) laws as described below, the Benefits described in the section of this Summary Plan Description entitled Benefits for Medicare Eligible Persons will apply to you and your Spouse and covered Dependent Children (if he or she is also eligible for Medicare and not affected by the MSP laws).

A series of federal laws collectively referred to as the "Medicare Secondary Payer" (MSP) laws regulate the manner in which certain employers may offer group health care coverage to Medicare eligible Employees, Spouses, and in some cases, Dependent Children.

The statutory requirements and rules for MSP coverage vary depending on the basis for Medicare and the medical plan coverage, as well as certain other factors, including the size of the employers sponsoring the group health plan. In general, Medicare pays secondary (after the Medical Plan makes its payment) to the following:

- The Medical Plan that covers individuals with end-stage renal disease ("ESRD") during the first 30 months of Medicare eligibility or entitlement. This is the case regardless of whetherthe individual has "current Employee status."
- In the case of individuals age 65 or over who still meet the definition of an Eligible Person.
- In the case of disabled individuals under age 65, if the individual or a member ofthe individual's family has "current Employee status."

Please Note: Call the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card should you have any questions regarding the ESRD primary period or other provisions of MSP laws and their application to you, your Spouse, or any Dependents.

Your Medicare Secondary Payer (MSP) Responsibilities

In order to assist CommonSpirit Health in complying with Medicare Secondary Payer (MSP) laws, it is very important that you promptly and accurately complete any requests for information from the Claims Administrator and/or CommonSpirit Health regarding the Medicare eligibility of you, your Spouse, and covered Dependent Children. This includes any requests for your Dependents' Social Security number. MSP laws require Claims Administrators to report the Social Security number of Dependents covered under this Plan who are eligible for Medicare. Failure to provide a requested Social Security number will result in the suspension of Claims payments by this Plan.

If you, your Spouse/Legally Domiciled Adult, or covered Dependent Child becomes eligible for Medicare, or has Medicare eligibility terminated or changed, please promptly contact the Medical Plan Customer Service Team at the toll-free number listed on the back of your ID card to ensure that your Claims are processed in accordance with applicable MSP laws.

This tutorial explains how the Plan pays for **Covered Services and Supplies**. Please keep in mind that not all services received will be covered under this Plan. You will pay the **full cost** for any services and supplies that are **not** covered under this Plan. Please refer to the sections of this Summary Plan Description titled The Details — What's Covered and Not Covered and General Conditions of Coverage, Exclusions, and Limitations for more information regarding what is covered and what is not covered by this Plan.

You will not be responsible for any amounts over the Eligible Charges for CommonSpirit Facilities or In-Network Providers. However, you will be responsible for your out-of-network Deductible, Coinsurance, and any additional amounts if you choose to go to an Out-of-Network Provider. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

Importantly, when the No Surprises Act applies, the amount you pay will be determined in accordance with the No Surprises Act and you will not be billed for more than the amount you would pay if the services had been provided by an In-Network Provider. The No Surprises Act typically applies to Emergency Services (including certain post-stabilization services) at an Out-of-Network facility, non-emergency items and services from Out-of-Network Providers at In-Network facilities, and air ambulance services.

Payments for CommonSpirit Facilities

For purposes of this document, local CommonSpirit Facilities may be considered part of the Enhanced network. You may receive an enhanced Benefit if you receive services from a CommonSpirit facility within the Enhanced network.

Under the Standard Health Plan option, the Deductible **will not** be applied to services billed as a Facility Charge on a Universal Billing (UB) form if you are admitted to a CommonSpirit Hospital or Facility for an Inpatient or an Outpatient procedure.

Under the Standard HDHP option, only Preventive Care services can be reimbursed under this option until your Deductible is met, even if you use a CommonSpirit facility.

An enhanced Coinsurance Benefit also applies to services billed as CommonSpirit Facility Charges on the UB bill. Any professional services rendered will be billed separately on an HCFA form by the Professional Providers, i.e., Physicians, Anesthesiologists, Radiologists, etc. These Providers are **not** considered to be CommonSpirit Facilities and their bills will be subject to the Deductible and paid at the applicable Coinsurance Benefit.

How the Plan Pays for Office Visits

For office visits, if you use an In-Network Provider the Billed Amount by the Physician will be reduced to the negotiated Eligible Charge. This negotiated eligible Charge often reflects a discount that the Physician has agreed to accept from the Plan Administrator. The Plan will pay the appropriate Coinsurance percentage shown in the Highlights of the Medical Plan Options section of this SPD for the option you elected. Under the Standard Health Plan option, the Deductible will not be applied to office visit charges. Under the Standard HDHP option, you must meet the Deductible before the plan begins to pay. These payments count toward the In-Network and Out-of-Network Out-of-Pocket Maximums.

An office visit includes the office visit and any services bundled with the office visit claim (meaning services performed by the provider; at the provider's office and during the office visit). Any services that are provided or billed by a different provider or at a different location (such as laboratory services, x-rays, office procedures or other ancillary charges) are still covered under the Plan but will be subject to the applicable Deductible and Coinsurance. For example, when blood is drawn during your office visit and the blood work is processed and billed by your physician, the charges would be bundled with the office visit claim and are subject to the applicable office visit Coinsurance. However, if that blood work is sent to a third party for analysis, the charges for the analysis do not fall under the office visit but would be subject to the applicable Deductible and Coinsurance.

How Does the Plan Pay for Office Visits for In-Network Providers?

This example illustrates how office visits are paid for In-Network Providers. Figures used are for illustration purposes and are not intended to reflect typical charges for a service. Only the office visit and services bundled with the office visit claim (meaning services performed by the provider, at the provider's office and during the office visit) will be subject to the office visit coinsurance and will not be subject to the Deductible. Any services that are provided or billed by a different provider or at a different location will be subject to applicable Deductible and Coinsurance.

Service Provided	Billed Amount	Eligible Charges	You Pay	
			Standard Health Plan	**Standard HDHP**
Primary Care Coinsurance			25%	20% after deductible
Office Visit	$180.00	$90.00	$22.50	$90.00
Blood draw and analysis* (at provider's office performed by and billed by the provider)	$25.00	$15.00	$3.75	$15.00
Total	$205.00	$105.00	$26.25	$105.00

* If blood work (including the draw and/or the analysis) is billed separately by an outside lab, the lab charges will be subject to the deductible and paid at the outpatient coinsurance percentage.

For an office visit, if you use an Out-of-Network Provider, they may bill for the difference between the billed amount and the Medicare allowed amount, and you would be responsible to pay that bill since the Out-of-Network provider does not have a contract with the Plan Administrator. Some Out-of-Network Providers may decide to waive this amount, but the Provider is not required to do so. Services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

How Does the Plan Pay for Office Visits for Out-of-Network Providers?

This example illustrates how office visits are paid for Out-of-Network Providers. Figures used are for illustration purposes and are not intended to reflect typical charges for a service. Office visit services provided to Jane by an Out-of-Network Providers are subject to the Deductible.

This example assumes that Jane's Deductible has been met and that none of the services received are preventive in nature. Jane's diagnosis is influenza.

Service Provided	Billed Amount	Eligible Charges	You Pay	
			Standard Health Plan	**Standard HDHP**
Primary Care Coinsurance			60% after deductible	60% after deductible
Office Visit	$180.00	$60.00	$36.00	$36.00
Blood draw and analysis† (at provider's office performed by and billed by the provider)	$25.00	$15.00	$9.00	$9.00
Total	$205.00	$75.00	$45.00	$45.00
Difference between billed amount and Maximum Allowed Amount*			$160.00	$160.00

*An Out-of-Network Provider may also bill for the difference between the billed amount and the negotiated amount, and you would be responsible to pay that bill since the Out-of-Network Provider does not have a contract with the Plan Administrator. Some Out-of-Network Providers may decide to waive this amount, but the Provider is not required to do so. Services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges

† If blood work (including the draw and/or the analysis) is billed separately by an outside lab, the lab charges will be subject to the deductible and paid at the out-patient coinsurance percentage.

How the Plan Pays for Preventive Care

For all Plan options, routine physical exams, well-woman exams (includes Pap smear), routine mammograms, routine pediatric exams, immunizations and other preventive services will be covered at 100 percent of the Eligible Charge. The Deductible will not be applied.

How the Plan Pays for Urgent Care Visits

There is a Copayment whenever you visit an urgent care facility. Please refer to the Highlights of the Medical Plan Options section of this SPD to find the appropriate urgent care. Copayment for the option you elected. Under the Standard Health Plan option, this Copayment is **not** subject to the Deductible. Under the Standard HDHP option, you must meet the Deductible before the plan begins to pay.

How the Plan Pays for Emergency Room Visits

There is a Copayment whenever you visit an Emergency room for an Emergency or Medically Urgent Situation. Please refer to the Highlights of the Medical Plan Options section of this SPD to find the appropriate Emergency Room Copayment for the option you elected. Under the Standard Health Plan option, this Copayment is not subject to the Deductible. Under the Standard HDHP option, you must meet the Deductible before the plan begins to pay. If you are

admitted to the Hospital, the Copayment is waived. For Emergency room visit purposes, Out-of-Network Providers will be treated the same as In-Network Providers consistent with the requirements of the Affordable Care Act and the No Surprises Act.

If your visit to the Emergency room is for a non-Emergency, the Eligible Charge (In-Network Providers) will be subject to the Deductible and the remainder of the charge/fee will be paid based on the Highlights of the Medical Plan Options, provided however, all such charges will be administered consistent with the terms of the No Surprises Act, when the No Surprises Act is applicable.

How to Save Money When Purchasing Prescription Drugs

The amount you pay for a Prescription Drug depends upon whether you purchase a Generic Drug, a Preferred Brand Formulary Drug, or a Non-Preferred non-Formulary Drug. You will save money if you purchase Generic Drugs, when available. The amount you pay also depends upon whether you purchase the drug through a CommonSpirit Pharmacy (if available), an in-network retail Pharmacy or the home delivery program.

You will save 50 percent off your copay/coinsurance cost if you are able to fill a 30 or 90-day prescription at a CommonSpirit Pharmacy. Visit Capital Rx's website at cap-rx.com and use the Find My Best Price tool. You can also visit the forms and documents page on the Capital Rx website for more information regarding the Home Delivery Pharmacy and the Specialty Pharmacy.

You can also save money if you use the home delivery program to purchase maintenance drugs. You can receive up to a 90-day supply of your medication and save money on your Copayment or Coinsurance amount, while experiencing the convenience of having your prescriptions mailed directly to your home address.

If the Pharmacy's charge is less than the Copayment or Coinsurance minimum amount, you pay the Pharmacy's charge for that drug. Please refer to the Highlights of the Medical Plan Options chart in this SPD for the Copayment and Coinsurance amounts for the option that you elected.

How the Deductible Works

You must meet a calendar year Deductible before this Plan pays Benefits for many Covered Services and Supplies. Please refer to the Highlights of the Medical Plan Options chart for information on services that are not subject to the calendar year Deductible (e.g., CommonSpirit Facility charges, Emergency room visits for Emergencies or Medically Urgent Situations, Preventive Care Services). The calendar year Deductible applies each January 1 to December 31.

There are two separate Deductibles, one for Covered Services rendered by In-Network Providers and one for Covered Services rendered by Out-of-Network Providers. Each Deductible is calculated separately, and the amounts are not combined. Copayments, such as the Emergency Room Copayment, office visit charges, charges for services performed in a CommonSpirit facility and billed as a facility charge and Prescription Drug charges do not apply to your Deductible under the Standard Health Plan. Under the Standard HDHP/HSA option, all services except preventive services apply to your Deductible. Penalties, such as pre-notification penalties, also do not apply to your Deductible. Please refer to the Highlights of the Medical Plan Options and The Details — What's Covered and Not Covered sections of this SPD to determine which services are subject to the Deductible.

If you have Individual Coverage, the Plan begins paying a percentage of your Eligible Charges after you meet your Individual Deductible for the remainder of the calendar year. Your Individual Deductible can be found on the Highlights of the Medical Plan Options under the option in which you enrolled.

The family Deductible works differently. If you have Family Coverage, you can meet your Deductible in one of two ways:

- An enrolled family member can meet the individual Deductible; or
- All family members can combine their Deductible expenses to meet the family Deductible.

Once your family Deductible is met, this Plan begins paying a percentage of your Eligible Charges for you and all of your enrolled Dependents for the remainder of the calendar year. If one enrolled family member meets the individual Deductible the Plan begins paying a percentage of his or her Eligible Charges for the remainder of the calendar year. That family member's expenses that were applied toward his or her individual Deductible will also count toward the family Deductible.

How Does the Family Deductible Work?
This example illustrates how the family Deductible works. Figures used are for illustration purposes and are not intended to reflect typical charges for a service.

Example #1

- Jane has Family Coverage for herself, her husband and her two kids.
- All care is from Network Providers.
- None of the charges are for Emergency room services.

For this example, we're only going to look at Jane's expenses:

Procedure	Eligible Charges	Amount Toward Deductible	
		Standard Health Plan	**Standard HDHP**
Preventive Office Visit	$200.00*	$0	$0
Outpatient Lab	$85.00	$85.00	$85.00
Outpatient X-ray	$125.00	$125.00	$125.00
20 Physical therapy visits	$600.00	$600.00	$600.00
Outpatient Surgery	$500.00	$500.00	$500.00
Outpatient Lab	$250.00	$250.00	$250.00
Follow-up X-ray	$125.00	$125.00	$125.00
Total		$1,685 ($1,750 Individual Deductible hasn't been met)	$1,685 ($3,200 Individual Deductible hasn't been met**)

*Total amount paid as preventive service. Deductible does not apply.

**As a reminder, each plan has a family Deductible. Individual Deductibles are combined to meet the family Deductible

Example #2

- Jane has Family Coverage for herself, her husband and her two kids.
- All care is from Network Providers.
- None of the charges are for Emergency room services.
- For simplicity, assume Jane's expenses were incurred first; her husband's expenses were incurred next; her son's expenses next; and her daughter's expenses incurred last.

Each family member has the following Eligible Charges:

Procedure	Eligible Charges	Amount Toward Deductible	
		Standard Health Plan	**Standard HDHP**
Jane's Expenses	$400.00	$400.00	$400.00
Husband's Expenses	$1,700.00	$1,700.00	$1,700.00
Son's Expenses	$1,200.00	$1,200.00	$1,200.00
Daughter's Expenses	$800.00	$350.00‡	$800.00
Total		$3,650.00 ($3,500 Family Deductible has been met; remaining $150 is applicable coinsurance	$4,100 $6,400 Family Deductible hasn't been met)

‡In- Network family Deductible is met. Balance of Eligible Charge will be paid at applicable Coinsurance percentage.

How Copayments Work

A Copayment is a specific dollar amount that you are asked to pay in order to receive a Covered Service or Supply. Examples of Copayments are the Emergency Room Copayment, Urgent Care Copayment and the Copayment when you are purchasing Generic Drugs. Under the Standard HDHP option, you are still responsible for meeting the Deductible even for services with a Copayment. Copayments under all the plan options are applied to your Out-of-Pocket Maximums.

How Coinsurance Works

Coinsurance is a percentage of the Eligible Charge. The Plan pays a percentage of those charges and you also pay a percentage of the charges. Many services that have a Coinsurance amount are first subject to the Deductible. Exceptions are the Coinsurance amounts under the Standard Health Plan option for office visits, services billed as CommonSpirit Facility charges, and charges for Prescription Drugs, since these services are not subject to the Deductible. The chart in the Highlights of the Medical Plan Options section of this SPD shows the Coinsurance amount that the Plan pays for each of the medical Plan options available.

The Coinsurance amount that you pay will be the difference between the Coinsurance amount that the Plan pays and 100 percent of the Eligible Charge.

How the Out-of-Pocket Maximum Works

The Plan limits the amount of money you have to pay out-of-pocket each year for covered services. This is your annual Out-of-Pocket Maximum. Coinsurance amounts, Copayment amounts and any expenses you pay toward your deductible apply toward your Out-of-Pocket Maximum. The amount you spend toward covered prescription drugs will also apply toward your annual in-network Out-of- Pocket Maximum. Once you reach the out-of-pocket limit, the Plan pays 100 percent of your covered expenses for the remainder of the year. The Out-of-Pocket Maximum amount is different for each medical plan option — refer to the Highlights of the Medical Plan Options section for details. If an Out-of-Network pharmacy is used, the member coinsurance does not apply to your Out-of-Pocket Maximums.

Note: There are individual Out-of-Pocket Maximum inserted (embedded) within the family Out-of- Pocket Maximum, so no family member would go over their individual Out-of-Pocket Maximum.

How the Plan Coordinates Cost Sharing with the No Surprises Act

Notwithstanding the foregoing, when the No Surprises Act applies, all cost sharing—including Deductibles, Copayments, and Coinsurance—will be equivalent to the cost sharing that would have been applicable if you had received the Covered Service(s) at an In-Network Provider. In addition, all amounts that you pay for items and services will accumulate toward your out-of-pocket maximum. The No Surprises Act typically applies to emergency services (including certain post-stabilization services) at an Out-of-Network facility, non- emergency items and services from Out-of-Network Providers at certain participating facilities, and air ambulance services.

There Are Three Different Levels of Benefits

There are three different Benefit levels. The level of Benefits that you receive depends on whether your care is provided by a CommonSpirit Facility, an In-Network Provider, or an Out-of-Network Provider. The highest level of Benefits will be paid for Facility Charges incurred at a CommonSpirit Facility.
The next highest level of Benefits will be paid for Eligible Charges incurred for Covered Services and Supplies provided by an In-Network Provider. The lowest level of Benefits will be paid for Eligible Charges incurred for Covered Services and Supplies provided by an Out-of-Network Provider.

Please keep in mind that you will receive the In-Network level of Benefits for services provided by an In-Network Provider, even when a CommonSpirit Facility is unavailable, unable, or unqualified to perform the services required. In no instance will an In-Network Provider ever be reimbursed at the CommonSpirit Facility rate. There will be no exceptions made.

With few exceptions, you will receive Benefits at the Out-of-Network level of Benefits if services are provided by an Out-of-Network Provider. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

However, if an In-Network Provider that is qualified to perform a particular service is not available within a 50-mile radius of your home address, Benefits will be paid at the In-Network Provider level of Benefits. Please seek pre-approval from the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card if you believe there is no In-Network Provider available and are seeking an exception to use an Out-of-Network Provider to be paid at the In-Network Provider level of Benefits. See the Network Details — Choosing a Provider section of this SPD.

Benefits described in this section will be provided only when you receive services on or after your Coverage Date and the services must be **Medically Necessary**. All Covered Services and Supplies listed in this section are subject to the General Conditions of Coverage, Exclusions, and Limitations section of this SPD. If a service or supply is not specifically listed, do **not** assume that it is a Covered Service. Benefits are typically **not** provided for services or supplies that are not specifically mentioned in this SPD.
If you are in doubt about a particular service being covered, or if you have any questions regarding the extent of coverage for a particular service or supply, please contact the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID Card.

For coverage levels, please refer to the Highlights of the Medical Plan Options section of this SPD for the Plan option that you elected. Please refer to the Glossary of Terms section of this SPD for the definitions of terms that are capitalized. Please refer to the Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD to find out which services require pre-notification for medical claims or Prior Authorization for Prescription Drug claims.
The Quick Reference — What's Covered and Not Covered section of this SPD may be used for a quick overview; however, please do **not** depend solely on that section of this SPD to obtain all of your Benefits information, as the exclusive use of that section might result in unanticipated out-of-pocket expenses.

The Benefits provided and the expenses that are your responsibility for the Covered Services will depend on whether you use an In-Network or Out-of-Network Provider. For purposes of this section, all CommonSpirit Facilities are covered at a richer enhanced facility Benefit and are not subject to the Deductible.

Services and supplies are listed in alphabetical order, and both Covered Services and Supplies and non- Covered Services and Supplies are listed within this section. If there is a "See Also" notation after a particular heading, please be sure to refer to the section(s) indicated to attain a complete picture of the covered Benefits, the Benefit limitations, and any exclusions. Remember, whenever the terms "you" and "your" are used, we also mean all eligible and enrolled Dependents.

Abortions

Covered:
Abortions are covered in a life-threatening situation where intervention is required.

Not Covered:
Benefits will not be provided for elective abortions except as stated above.

See Also:
Contraceptives and Contraceptive Devices later in this section.
Sterilization Procedures later in this section.

Acupuncture

Covered:
Benefits will be provided for Acupuncture when these services are rendered by a Physician or licensed Acupuncturist. Your Benefits for Acupuncture will be limited to a maximum of 10 visits per Benefit Year. This is a combined maximum for services rendered by an In-Network Provider, and/or an Out- of- Network Provider.

Not Covered:
Benefits will not be provided for Acupuncture services that are not rendered by a Physician or licensed Acupuncturist.

Allergy Testing and Treatment

Covered:
Benefits for allergy testing and treatment are covered 100 percent. Benefits for allergy testing and treatment are subject to the Deductible under the Standard HDHP option.

Ambulance Transportation

Covered:
Benefits will be provided for Medically Necessary Ambulance Transportation from your home, or the scene of Accident, Emergency, or Medically Urgent Situation to a Hospital, between Hospitals, between a Hospital and a Skilled Nursing Facility, or from a Hospital or Skilled Nursing Facility to your home.

Except as otherwise required by the No Surprises Act, costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

In addition, where the No Surprises Act applies to air ambulance services, you will not be billed for the difference between the amount charged and the total amount allowed by the Plan.

Not Covered:
Benefits will not be provided for long distance trips or for use of an Ambulance because it is more convenient than other transportation.

See Also:
Inpatient Hospital Care later in this section.
Home Health Care later in this section.
Human Organ Transplants later in this section.
Skilled Nursing Facilities later in this section.
Transportation and Lodging later in this section.

Ambulatory Surgical Facilities

Covered:
Ambulatory Surgical Facilities are covered under the outpatient level of Benefits.

Anesthesia Services

Covered:
Anesthesia Services and the administration of anesthesia by a Covered Provider are covered if administered at the same time as a covered surgical procedure in a Hospital, Ambulatory Surgical Facility, or surgeon's office. Benefits will also be provided for Anesthesia Services administered by oral and maxillofacial surgeons when such services are rendered in the surgeon's office or Ambulatory Surgical Facility, if such services are also covered under this Plan.

Not Covered:
Benefits will not be provided for anesthesia used during surgical procedures, such as cosmetic procedures, that are not covered under this Plan. Additionally, local or topical anesthesia billed separately from related surgical or medical procedures are not covered.

See Also:
Acupuncture earlier in this section.
Cosmetic Surgery later in this section.
"-ologists" at In-Network and CommonSpirit Facilities later in this section.
Surgery later in this section.

Applied Behavior Analysis (ABA) Therapy

Covered:
Benefits will be provided for ABA therapy when Applied Behavior Analysis services are performed or supervised pursuant to an approved treatment plan by a licensed physician or psychologist or a master's or doctoral degree holder certified by the National Behavior Analyst Certification Board with a designation of board-certified behavior analyst. The Mental Health Services benefit will apply for this type of service.

Assistant Surgeons

Covered:
Benefits will be provided for a Physician, Dentist, Podiatrist, or Registered Surgical Assistant who assists the operating surgeon in performing covered Surgery.

Not Covered:
Benefits will not be provided for assistant Surgery services that are not determined to be Medically Necessary or that are for surgical procedures that are not covered under this Plan.

See Also:
Eligible Charges for Multiple Surgical Procedures later in this section.
Surgery later in this section.

Blood and Blood Administration

Covered:
Blood and blood administration, including blood derivatives and blood components are covered under this Plan.

Not Covered:
Benefits are not provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Surgery later in this section.

Cardiac Rehabilitation Services

Covered:
Your Benefits for cardiac rehabilitation services are covered if they are Medically Necessary. Medically supervised Cardiac rehabilitation (CR) programs may be considered Medically Necessary for patients with a history of the following Conditions and/or procedures:

- Acute myocardial infarction (MI) also known as heart attack;
- Coronary artery bypass graft (CABG) Surgery;
- Percutaneous transluminal coronary angioplasty (PTCA);
- Heart Valve Surgery;
- Heart transplantation;
- Stable Angina pectoris;
- Congestive heart failure; and
- Transmyocardial revascularization.

A cardiac rehabilitation treatment plan may be considered Medically Necessary for three sessions per week for up to a 12-week period (36 sessions). Programs are to start within 90 days of the cardiac event and be completed within six months of the cardiac event.

Chemotherapy Treatments

Covered:
The use of chemical agents to treat or control a serious Illness is covered.

Not Covered:
Benefits will not be provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Cyber Knife Surgery later in this section.
Radiation Therapy Treatments later in this section.
Wigs or Hair Pieces later in this section.

Chiropractic Care

Covered:
Benefits will be provided for muscle manipulations (chiropractic care). Muscle manipulations must be performed by a licensed Chiropractor or a Physician. Chiropractic care is limited to a Benefit Year maximum of 20 visits per covered individual for both In-Network and Out-of-Network Providers combined.

Completion of Claim Forms, Reports, or Medical Records

Not Covered:
Benefits are not provided for charges to complete Claim forms, reports, or medical records.

Complications of Non-Covered Services/Treatments

Not Covered
Except as otherwise described in this SPD, care, services or treatment required as a result of complications from a service or treatment not covered under the Plan are not covered.

Consultations

Covered:
Benefits for consultations when you are in Inpatient in a Hospital or Skilled Nursing Facility are covered. The consultation must be requested by your attending Physician and consist of another Physician's advice in the diagnosis or treatment of a Condition which requires special skill or knowledge.

Not Covered:
Benefits will not be provided for a consultation done because of Hospital regulations or by a Physician who renders Surgery or Maternity Service during the same Admission.

Benefits also will not be provided for telephone consultations or providing information concerning a Claim.

Contraceptives and Contraceptive Devices

Covered:
If you work for a for-profit CommonSpirit Health market*, the following FDA-approved preventive contraception services and prescriptions are covered through the Medical Plan:

- Medical: Patient education and counseling on contraceptives, administration of certain contraceptives (such as the insertion of IUD's or injections) and women's sterilization procedures.
- Prescription drugs: Generic contraceptives, over-the-counter contraceptives with a prescription, and multi-source brand contraceptives (when a doctor determines it Medically Necessary) and it is on the Capital Rx Woman's Health Birth Control products list.

If you work for a non-profit CommonSpirit Health market, you will need to work directly with your medical and prescription plan administrator to receive preventive coverage for the services listed above at 100 percent. Our non-profit business lines fall under a religious exemption to the contraceptive mandate and therefore the Medical Plan does not cover these services.

*For- profit CommonSpirit Health markets include: Center for Translational Research, St. Michael Medical Center, St. Joseph's Regional Services, Mountain Management, and Mercy Services Corp.

Not Covered:
If you work for a non-profit CommonSpirit Health market, benefits will not be provided for contraceptives (oral or non-oral dosage forms) and contraceptive devices used to prevent conception, even if deemed Medically Necessary. You will need to work directly with your medical and prescription plan administrator to receive preventive contraceptive coverage.

See Also:
Sterilization Procedures later in this section.

Cosmetic Surgery

Covered:
Reconstructive Surgery following a mastectomy or when Medically Necessary to correct damage caused by an Accident, an Accidental Injury, or to correct a congenital defect.

Not Covered:
Benefits will not be provided for cosmetic Surgery and related services and supplies except as stated within this SPD.

See Also:
Surgery later in this section.

COVID-19 Testing and Treatment

Covered:
Benefits for Medically Necessary diagnostic and serological testing and treatment of COVID-19 shall be covered as follows: (i) COVID-19 Testing (in office) shall be covered at the same level as general Diagnostic Services; (ii) COVID-19 related Office Visits shall be covered at the same level as Office Visits (Primary Care or Specialists, as applicable); and (iii) COVID-19 vaccines shall be covered at the same level as Preventive Care at an Enhanced Network, In-Network (INN) or Out-of-Network (OON) provider, as applicable, and may also be covered at a network pharmacy with our pharmacy plan coverage under CommonSpirit Health's Prescription Drug benefit program.

Not Covered:
Over-the-counter ("OTC") diagnostic testing.

Custodial Care Services

Not Covered:
Benefits will not be provided for Custodial Care Services.

See Also:
Home Health Care later in this section.
Skilled Nursing Facilities later in this section.

Cyber Knife Surgery

Covered:
Cyber knife surgery is a covered service if it is deemed Medically Necessary.

See Also:
Chemotherapy Treatments earlier in this section.
Radiation Therapy Treatments later in this section.

Dental Services

Covered:
Benefits will only be covered under this Plan in the absence of other dental coverage for these procedures or through coordination of medical and dental Benefits, when appropriate. Please see the Coordination of Your Benefits with Other Plans and Responsible Parties section of this SPD for information on how the coordination of Benefits works.

Coverage for dental services is limited to the following:

- Dental services rendered by a Dentist or Physician which are required as the result ofan Accidental Injury of the teeth, jaws, cheeks, lips, tongue, roof, and floor of the mouth;
- Surgical removal of impacted teeth as an Inpatient or Outpatient procedure in a facilityonly when you have a medical Condition (such as hemophilia) that required hospitalization;
- Excisions of tumors or cysts of the jaw, cheeks, lips, tongue, roof, and floor of the mouth;
- Labial and lingual frenectomies;
- Excisions of exostoses of the jaws and hard palate (provided that this procedure is not donein preparation for dentures or other prosthesis;
- External incision and drainage of cellulitis;
- Incision of accessory sinuses, salivary glands, or ducts;
- Reduction of dislocation of, or excision of, the temporomandibular joints;
- Surgical Treatment of Temporomandibular Joint Dysfunction (TMJ); and
- Jaw dislocation manipulation.

Treatment for dental injuries must be performed within 12 months of the injury in order for the services to be covered under the Medical Plan.

Not Covered:
Benefits will not be provided for dental services or materials, except as described above. This exclusion includes, but is not limited to, diagnostic and preventive dental services, restorative services, endodontic services, periodontal services, surgical removal of impacted teeth (except as noted above), dental cast restorations, dentures, bridges, orthodontic services, injuries associated with the act of chewing, maxillary and mandibular tooth implants (osseointegration), and non-surgical treatment of Temporomandibular Joint Dysfunction (TMJ) and Related Disorders.

See Also:
Temporomandibular Joint Dysfunction and Related Disorders later in this section.

Diabetes Training Programs

Covered:
Diabetes training and education programs for the self-management of all types of diabetes mellitus by a Diabetes Educator are covered. All covered training or education must be prescribed by a licensed Physician.

This program may be designed to help any type of diabetic and his or her family understand the diabetes disease process and the daily management of diabetes; this includes nutrition education to improve your understanding of your metabolic nutritional Condition and provide you with information to manage your nutritional requirements. Nutrition education related to the diagnosis of diabetes mellitus is appropriate for, but not limited to:

- Glucose intolerance;
- High Blood Pressure;
- Lactose intolerance; and
- Morbid obesity.

Diagnostic Services

Covered:
Benefits will be provided for those services related to covered Surgery or Medical Care.

See Also:
Genetic Testing later in this section.

Digital Breast Tomosynthesis (3D Mammograms)

Covered:
Benefits will be provided for 3D mammograms including unilateral and bilateral digital breast tomosynthesis.

Durable Medical Equipment

Covered:
Benefits will be provided for such things as internal cardiac valves, internal pacemakers, mandibular reconstruction devices (not used primarily to support dental prosthesis), bone screws, bolts, nails, plates, and other internal and permanent devices deemed Medically Necessary are covered.

Benefits will be provided for diabetic members for an insulin pump when medically necessary and related supplies to support the function and use of the insulin pump when needed.

Benefits will also be provided for the rental (but not to exceed the total cost of the equipment) or purchase of durable medical equipment required for temporary therapeutic use provided that this equipment is primarily and customarily manufactured and used to serve a medical purpose. The Claims Administrator will determine whether to pay the rental amount or the purchase price amount for an item and will also determine the length of any rental term based on the needs of the patient and the cost of the item. Examples of covered items include, but are not limited to, wheelchairs, hospital-type beds, artificial respirators, crutches, casts, oxygen, and equipment needed to administer oxygen.

Benefits will be provided for maintenance and repairs of purchased equipment; however, maintenance needed due to misuse or abuse is not covered. Benefits will also be provided for replacement if needed because of a change in your physical condition and it is likely to cost less to replace the item than to repair the existing item or rent a similar item.
Not Covered:
Benefits will not be provided for items that are not primarily and customarily manufactured and used to serve a medical purpose. Examples of items not covered include, but are not limited to, hot tubs, swimming pools, exercise equipment, braces, splints, appliances, battery implants, humidifiers, air conditioners, elastic stockings or bandages including trusses, lumbar braces, garter belts, and similar items that can be purchased without a prescription.

The Plan limits coverage to one item of equipment for the same or similar purpose and the accessories needed to operate the item. You are responsible for the entire cost of any additional pieces of the same or similar equipment you purchase or rent for personal convenience or mobility.

See Also:
Foot Care and Foot Orthotics later in this section.
General Conditions of Coverage, Exclusions, and Limitations section of this SPD.
Leg, Back, Arm and Neck Braces later in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Prosthetic Appliances and Devices later in this section.

Educational or Training Programs

Covered:
Diabetes training programs by Diabetes Educators are covered through the medical carrier. Contact the medical carrier for assistance. Nutrition and re-education programs are also covered in conjunction with weight loss surgery.

Not Covered:
With the exception of the above-mentioned programs, Benefits will not be provided for treatment or services that are provided for educational or training purposes.

See Also:
Diabetes Training Programs earlier in this section.

Eligible Charges for Multiple Surgical Procedures

Covered:
If you or one of your Dependents undergo two or more operations during any one time, covered charges for the services of the Physician for each procedure that is clearly identifiable as a separate procedure will be based on:

- 100 percent of Eligible Charges for the first or primary operation; and
- 50 percent of Eligible Charges for the second or subsequent operation.

Emergency Services

Covered:
Benefits for Emergency Accident Care or Emergency Medical Care will be provided at 100 percent of the Eligible Charge after the applicable Copayment if it meets the definition of an Emergency or Medically Urgent Situation as found in the Glossary of Terms section of this SPD. This Benefit will be the same when services are rendered from a CommonSpirit Facility, an In-Network Provider, or an Out-of-Network Provider. The Copayment will be waived if you are admitted as an Inpatient.

Under the Standard HDHP option, you must meet the Deductible before the plan begins to pay benefits for Emergency Accident Care and Emergency Medical Care. However, if admitted to the Hospital, the Copayment will be waived, and Inpatient pre-notification requirements, as well as Inpatient Benefits will apply.

When the No Surprises Act applies to Emergency Services, you will not be billed for the difference between the amount charged and the total amount allowed by the Plan. If you receive Medically Necessary Emergency Services to treat an emergency medical condition, those services will be covered as required under the No Surprises Act notwithstanding any other plan provision to the contrary.

See Also:
Ambulance Transportation earlier in this section.
Non-Emergency Use of the Emergency Room later in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.

Eye Examinations and Eye-Related Diagnostic Services

Covered:
Benefits will be provided for eye examinations for the purpose of diagnosing a medical Condition, such as eye exams or refractions to diagnose or treat diabetes. In addition, routine vision exams will be covered, but only for newborns and Children when billed as part of a well-child visit. One eye exam and refraction will be allowed following cataract surgery.

Not Covered:
Benefits will not be provided for examinations to determine the refractive state of the eyes, auditory problems, surveys, case findings, research studies, screenings, or similar procedures and studies, or tests which are Investigational in nature.

See Also:
Eyeglasses, Contact Lenses, or Cataract Lenses later in this section.
Kerato-Refractive Eye Surgery later in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Optometry Services later in this section.
Retinal Eye Exam later in this section.
Vision Services later in this section.

Eyeglasses, Contact Lenses, or Cataract Lenses

Covered:
The first pair of either eyeglasses or contact lenses needed after cataract Surgery, cornea transplantation, or cornea grafting is covered.

Not Covered:
Benefits will not be provided for eyeglasses, contact lenses, or cataract lenses with the exception of the first pair for the Conditions listed above.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Kerato-Refractive Eye Surgery later in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Optometry Services later in this section.
Vision Services later in this section.

Failure to Keep a Scheduled Appointment

Not Covered:
Benefits will not be provided for charges for failure to keep a scheduled appointment.

Family Members Who Provide Services

Not Covered:
Benefits will not be provided for medical services and supplies provided by a member of your family or household. “Member of your family” means yourself; your Spouse; Legally Domiciled Adult; natural or adoptive parent; Child; sibling; stepparent or stepchild; step or half-brother; step or half- sister; mother-in-law or father-in-law; son-in-law or daughter-in-law; brother-in-law or sister-in-law; grandparent or grandchild; or Spouse of a grandparent or grandchild.

Fertility Treatment

Covered:
Expenses for Covered Services related to the diagnosis and/or medical treatment of Infertility when rendered in conjunction with conception through normal intercourse are covered. Fertilization must occur within the woman’s body.

Your Benefits for the medical treatment of Infertility and all related services and supplies are subject to a Lifetime Maximum of $15,000 per covered individual. Fertility drugs are limited to a separate Lifetime Maximum of $5,000 per covered individual.

Not Covered:
Benefits will not be provided for services and supplies rendered or provided for the treatment of fertility in which fertilization takes place outside of the woman’s body. Specifically excluded, without limiting this exclusion to these procedures, are all services and supplies related to in-vitro fertilization, artificial insemination, embryo transfers, donor charges, Zygote Intrafallopian Transfer (ZIFT), cryopreservation and surrogate parent services.

Foot Care and Foot Orthotics

Covered:
Benefits will be provided twice during the Benefit Year for Medically Necessary custom-made foot orthotics provided by an Orthotic Provider. Benefits are also provided for foot care that is determined to be Medically Necessary.
See Also:
Durable Medical Equipment earlier in this section. Leg, Back, Arm, and Leg Braces later in this section. Prosthetic Appliances and Devices later in this section.

Gender Affirmation Treatment

Covered:
All Medically Necessary services for the treatment of gender identity disorder or gender dysphoria as diagnosed in accordance with the diagnostic criteria in the current edition of the Diagnostic and Statistical Manual of Mental Disorders.

Not Covered:
All gender affirmation treatments and services for individuals who have not been diagnosed with gender identity disorder or gender dysphoria.
Any gender affirmation treatment or service (or portion thereof) that is not Medically Necessary.

Genetic Testing

Covered:
Genetic molecular testing (specific gene identification) and related counseling are covered when both of the following requirements are met:

- You are an appropriate candidate for a test under medically recognized standards (forexample, family background, past diagnosis, etc.); and
- The outcome of the test is expected to determine a covered course of treatment orprevention and is not merely informational.

See Also:
Diagnostic Services earlier in this section.

Hearing Examinations and Hearing Aids

Covered:
Benefits will be provided for hearing examinations for the purpose of diagnosing a medical Condition. In addition, routine hearing examinations will be covered, but only for newborns and Children when billed as routine and included as a part of a well-child visit.

Not Covered:
Benefits will not be provided for pure tone audiometry tests, when part of a routine diagnosis. Benefits are not provided for hearing aids or the examinations for the prescription or fitting of hearing aids.

Home Health Care

Covered:
Comprehensive medical Covered Services will include charges by a Home Health Care Program or agency for:

- Private Duty Nursing Services;
- Part-time or intermittent home care by a home health aide;
- Physical, Occupational, Speech, or respiratory therapy;
- Intermittent services of a registered dietician or social worker;
- Part-time or intermittent home care by any other individual of the home health careteam;
- Drugs and medicines which require a Physician's prescription, as well as othersupplies prescribed by the attending Physician; or
- Laboratory services;

The above charges are covered only to the extent that such services and supplies are provided under the terms of a Home Health Care Plan. These Covered Services are subject to all provisions of the Medical Plan that would apply to any other medical treatment or service.

The home health care services must be rendered in accordance with a prescribed Home Health Care Plan. The Home Health Care Plan must be:

- Established prior to the initiation of the home health care services;
- Prescribed by the attending Physician at least once every 30 days; and
- Required as a result of an Illness or Accidental Injury.

Pre-notification is required prior to the initiation of home health care to assist you or your Dependent in determining whether or not the proposed treatment or service is Medically Necessary and appropriate for reimbursement under this Plan. The general comprehensive medical limitations and maximums listed in this SPD will apply to home health care.

Not Covered:
Comprehensive medical Covered Services for home health care will not include:

- Services or supplies not included in the Home Health Care Plan;
- The services of any person in your or your Dependent's immediate family, or any person who normally lives in your or your Dependent's home;
- Custodial Care (services or supplies provided to assist a person in daily living, e.g., meals and personal grooming); or
- Transportations services.

See Also:
Ambulance Transportation earlier in this section.
Family Members Who Provide Services earlier in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.

Hospice Care Program Services

Covered:
Benefits will be provided for Hospice Care Program Services as described below when these services are rendered to you by a Hospice Care Program Provider. However, for Benefits to be available, you must have a terminal Illness with a life expectancy of 12 months or less, as certified by your attending Physician; and you will no longer benefit from standard Medical Care or have chosen to receive Hospice care rather than standard care. Also, a family member or friend should be available to provide custodial type care between visits from the Hospice Care Program Providers if Hospice care is being provided in the home.

The following are eligible Hospice Care Program Providers:

- Hospice facility;
- Hospital;
- Convalescent facility; and
- Home Hospice.

The following services are covered under the Hospice Care Program:

- Home Health Care;
- Medical supplies and dressings;
- Prescription medication;
- Skilled and non-Skilled Nursing Services;
- Occupational Therapy;
- Pain management services;
- Physical Therapy;
- Physician visits;
- Medical social services under the direction of a Physician;
- Psychological and dietary counseling; and
- Bereavement counseling.

Benefit payment for Covered Services rendered by a Hospice Care Program Provider will be provided at the same level as Inpatient Hospital Covered Services.

See Also:
Family Members Who Provide Services earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Personal Hygiene, Comfort, and Convenience Items later in this section.

Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary

Not Covered:
Benefits will not be provided for services which are not determined to be Medically Necessary.
Hospitalization is not Medically Necessary when, in reasonable medical judgment, the medical services provided did not require an acute Hospital Inpatient (overnight) setting, but could have been provided in a Physician's office, the Outpatient department of a Hospital, or some other setting without adversely affecting the patient's Condition.

Examples of hospitalization and other health care services that are not Medically Necessary include but are not limited to:

- Hospital Admissions for or consisting primarily of observation and/or evaluation that could have been provided safely and adequately in some other setting, e.g., a Physician's office or Hospital Outpatient department;
- Hospital Admissions primarily for diagnostic studies (x-ray, laboratory and pathological services, and machine diagnostic tests) which could have been provided safely and adequately in some other setting, e.g., Hospital Outpatient department or Physician's office;
- A continued Inpatient Hospital care, when the patient's medical symptoms and Condition no longer require continued stay in a Hospital;
- Hospitalization or Admission to a Skilled Nursing Facility, nursing home, or other facility for primary purposes of providing Custodial Care Services, convalescent care, rest cures, or domiciliary care to the patient;
- Hospitalization or Admission to a Skilled Nursing Facility for the convenience of the patient or Physician or because care in the home is not available or is unsuitable; and
- The use of skilled or private duty nurses to assist in daily living activities or routine supportive care or to provide services for the convenience of the patient and/or family members.

The examples above do not comprise an exhaustive list of hospitalizations or other services and supplies that are not Medically Necessary.

The Claims Administrator will make the decision whether hospitalizations or other health care services or supplies are Medically Necessary and whether they are eligible for payment under the terms of the Medical Plan.

In some instances, this decision may be made by the Claims Administrator after you have been hospitalized or have received other health care services and after a Claim for payment has been submitted. The fact that your Physician may prescribe, order, recommend, approve, or view hospitalization or other health care services or supplies as Medically Necessary, does not make the hospitalization, services, or supplies Medically Necessary under the Medical Plan and does not mean that hospitalization, services, or supplies will be covered under the Plan.

See Also:
Assistant Surgeons earlier in this section.
Inpatient Hospital Care later in this section.
Outpatient Hospital Care later in this section.
Physicians later in this section.
Skilled Nursing Facilities later in this section.
Surgery later in this section.

Human Organ Transplants

Covered:
The following human-to-human organ transplant procedures will be considered Covered Services, subject to all limitations and maximums described in this SPD, for a patient that is covered under this Plan. Benefits will only be covered for Medically Necessary procedures that are not Investigational for your specific Condition. These include:

- Cornea;
- Kidney;
- Bone Marrow;
- Peripheral stem cell infusion;
- Heart Valve;
- Muscular-skeletal;
- Parathyroid;
- Heart;
- Lung;
- Heart/lung;
- Liver;

- Pancreas;
- Small bowel;
- Pancreas/Kidney; and
- Tissue transplants.

Benefits are potentially available to both the recipient and donor of a transplant as follows:

- If both the donor and the recipient have medical coverage, each will have their Benefits paid by their own Plan.
- If you are the recipient of the transplant, and the donor for the transplant has no other medical coverage from any other source:
  - The Benefits described in this section of the SPD will be provided for both you and the donor.
  - Payments made for the donor will be charged against your Benefits and will be limited solely to the services deemed Medically Necessary to carry out the human organ transplant.
  - The donor's coverage under this Plan will not extend beyond their discharge from the hospital after the human organ transplant procedure.
- If you are the donor for the transplant and no other medical coverage is available to you from any other source, the Benefits described in this SPD will be provided for you. However, no Benefits will be provided for the recipient.

Benefits will be provided for:

- Inpatient and Outpatient Covered Services related to the transplant Surgery;
- Evaluation, preparation, and delivery of the donor organ;
- Removal of the organ from the donor; and
- Transportation of the donor organ to the location of the transplant Surgery; however, Benefits will be limited to the transportation of the donor organ in the United States or Canada.

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

- The Medical Plan Customer Service Team will furnish you with the names of Hospitals which are approved Human Organ Transplant Program Hospitals, or you may use a CommonSpirit Facility.
- Covered Services will include cryopreservation and storage of bone marrow or peripheralstem cells when the cryopreservation and storage is part of a protocol of high dose Chemotherapy, which has been determined to be Medically Necessary.
- The Benefit for cryopreservation and storage of bone marrow or peripheral stem cells will not exceed $10,000 per approved transplant in a non-CommonSpirit Facility Hospital or a hospital that is not a Human Organ Transplant Program Hospital.
- If you are the recipient of the transplant, and such transplant occurs at a Human Organ Transplant Program Hospital or a CommonSpirit Facility Hospital, Benefits will be provided for reasonable, demonstrated transportation and lodging for you and a companion. The cost of meals may also be included but **only** if the meals are provided by a Human Organ Transplant Program Hospital or a CommonSpirit Facility Hospital **and** the principal reason for being in such location is to receive the transplant. If the recipient of the transplant is a Dependent Child under the age of 19, Benefits for transportation and lodging will be provided for two companions. For Benefits to be available, your place of residency must be more than 50 miles from the Hospital where the transplant will be performed.
  - Benefits for reasonable, demonstrated transportation, lodging (lodging is limited to $50 per person, per day), and meals are limited to a maximum of $10,000 per transplant. This includes all transplants.
  - Airfare is reimbursable only if the travel distance from your home to the designated transplant facility is 200 miles or more.

Not Covered:
Benefits will not be provided for:

- Transplants that are not Medically Necessary or are Investigational in nature;
- Cardiac rehabilitation services when not provided to the transplant recipient immediately following discharge from a Hospital for transplant Surgery;
- Travel time and related expenses required by a Provider;
- Drugs which are Investigational or do not have approval of the Food and Drug Administration;
- Cryopreservation and storage, except as described above;
- Animal-to-human organ transplants;
- Implantation within the human body of artificial or mechanical devices designed to replace human organ(s); and
- Services provided to any individual who is not the recipient or actual donor unlessspecified above.

See Also:
Notification Requirement and Care Coordination section of this SPD.
Surgery later in this section.
Travel and Lodging later in this section.

Inpatient Hospital Care

Covered:
The following are Covered Services when you receive them as an Inpatient in a Hospital:

- Bed, board and general nursing care when you are in
    - A semi-private room;
    - A private room, when Medically Necessary;
    - An Intensive Care Unit; or
    - A Coronary Care Unit.
- Ancillary services (such as operating rooms, drugs, surgical dressings, x-rays, and lab work)

If you are in a private room, Benefits will be limited by the Hospital's rate for its most common type of room with two or more beds, unless the use of a private room is determined to be Medically Necessary.

Not Covered:
Benefits will not be provided for hospitalizations which are not Medically Necessary. Additionally, personal hygiene, comfort and convenience items such as telephones, televisions, and guest trays are not covered.

See Also:
Ambulance Transportation earlier in this section.
Anesthesia Services earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Chemotherapy Treatments earlier in this section.
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Custodial Care Services earlier in this section.
Diagnostic Services earlier in this section.
Emergency Services earlier in this section.
Family Members Who Provide Services earlier in this section.
Genetic Testing earlier in this section.
Home Health Care earlier in this section.
Hospice Care Program Services earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Occupational Therapy later in this section.
"-ologists" at In-Network and CommonSpirit Facilities later in this section.
Outpatient Hospital Care later in this section.
Oxygen and Its Administration later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Physical Therapy later in this section.
Physicians later in this section.
Pre-Admission Testing later in this section.
Radiation Therapy Treatments later in this section.
Shock Therapy Treatments later in this section.
Skilled Nursing Facilities later in this section.
Speech Therapy later in this section.
Substance Use Disorder Treatment later in this section.
Surgery later in this section.
X-Ray and Laboratory Services later in this section.

Kerato-Refractive Eye Surgery

Not Covered:
Benefits will not be provided for treatment or services or materials for Kerato-Refractive Eye Surgery (Surgery to improve near-sightedness and/or astigmatism by changing the shape of the cornea, including but not limited to radial keratotomy and keratomileusis Surgery).

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses and Cataract Lenses earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Optometry Services later in this section.
Vision Services later in this section.

Leg, Back, Arm and Neck Braces

Covered:
Benefits will be provided for leg back, arm, and neck braces.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Prosthetic Appliances and Devices later in this section.

Marriage Counseling

Covered:
Benefits will be provided for Marriage Counseling when provided by a pastoral counselor, licensed mental health counselor, Licensed Marriage and Family Therapist or a licensed Psychologist. When you receive Covered Services in an In-Network Provider's office for marriage counseling, these services will be paid at the same level of Benefits as an office visit.

Massage Therapy

Not Covered:
Benefits will not be provided for Massage Therapy.

See Also:
Occupational Therapy later in this section.
Physical Therapy later in this section.
Speech Therapy later in this section.

Mastectomy and Related Services

Covered:
Benefits for Covered Services related to mastectomies are the same as for any other Condition. Covered Services include, but are not limited to:

- Reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications of all stages of the mastectomy including, but not limited to lymphedemas.

See Also:
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes later in this SPD.
Prosthetic Appliances and Devices later in this SPD.

Maternity Services

Covered:
Your Benefits for Maternity Services are the same as your Benefits for any other Condition. Benefits will be provided for Covered Services rendered by a Physician, Physician's Assistant, Nurse Practitioner, or Certified Nurse-Midwife.

Benefits will be paid for Covered Services received in connection with both normal pregnancy and complications of pregnancy. The following Preventive Care services related to Maternity Services will be covered at 100 percent, as required by the Patient Protection and Affordable Care Act:

- Purchase of a standard (non-hospital grade) electric breast pump within the first 60 days following delivery;
- Purchase of a manual breast pump within the first 12 months (365 days) following delivery;
- Rental of a heavy duty electrical (hospital grade) breast pump for the period of time that a newborn is detained in the hospital; and
- For women using a breast pump from a prior pregnancy, a new set of breast pump supplies will be covered with each subsequent pregnancy within the first 12 months following delivery.
- Prenatal care received by a pregnant female is limited to pregnancy-related physician office visits including the initial and subsequent history and physical exams of the pregnant woman (maternal weight, blood pressure and fetal heart rate check). Prenatal physician office visits will only be covered at 100 percent if they are billed separately from other services that arenot covered at 100 percent as Preventive Care.

If the newborn Child needs treatment for an Illness or Accidental Injury, the newborn must be enrolled in the Medical Plan as a Dependent. You must enroll your newborn within 60 days after birth for the infant to be covered under the Plan. If enrolled within 60 days of birth, the newborn's coverage will be effective from the date of the birth.

Not Covered:
Benefits will not be provided for nursery charges once the mother is discharged from the Hospital or any other charges not explicitly listed above as a Covered Service if your newborn does not meet the definition of a Dependent Child or if the newborn is not enrolled in the Plan within 60 days of birth.

See Also:
Adding or Dropping Coverage section of this SPD.
Glossary of Terms section of this SPD.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD. .
Personal Hygiene, Comfort and Convenience Items later in this section.

Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes

Covered:
Benefits are provided for medical and surgical dressings, supplies, casts, splints, crutches, and artificial eyes.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.
Modifications to Homes, Property, or Automobiles later in this section.
Prosthetic Appliances and Devices later in this section.

Mental Health Services

Covered:
Benefits for all of the Covered Services previously described in this SPD are available for the diagnosis and/or treatment of an Illness Affecting Mental Health. Medical Care for the treatment of an Illness Affecting Mental Health is covered when rendered by a:

- Physician;
- Psychologist, Clinical Social Worker, or Clinical Professional Counselor working within the scope of his or her license; Licensed spiritual counselor who holds a pastoral counseling degree; or
- Licensed Marriage Family Therapist.

Additional counselors may also be covered when supervised by a Physician. Please contact the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card for more information.

See Also:
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Custodial Care Services earlier in this section.
Failure to Keep a Scheduled Appointment earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Marriage Counseling earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Residential Treatment Facilities later in this section.
Substance Use Disorder Treatment later in this section.

Modifications to Homes, Property, or Automobiles

Not Covered:
Benefits shall not be provided for modifications made to a home, property, or automobile, such as ramps, elevators, spas, and car hand controls.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Prosthetic Appliances and Devices later in this section.

Nephropathy Screening

Covered:
Benefits for screening to detect kidney disease resulting from diabetes.

Not Covered:
Benefits shall not be provided for non-diabetic patients.

See Also:
Diabetes Training Programs earlier in this section.
Diabetes Support Program section of this SPD.
Retinal Eye Exam later in this section.

Non-Emergency Use of the Emergency Room

Covered:
Benefits for non-Emergency use of the Emergency room will be provided based on the Highlights of the Medical Plan Options.

See Also:
Emergency Services earlier in this section.

Non-Prescription Drug Medications

Covered:
Benefits will be provided for Vitamin B-12 injections when determined to be Medically Necessary. Additionally, enteral feedings will be covered as part of a Hospice Care Program Service or if the sole source of feeding, such as for someone who has oral or throat cancer.

Not Covered:
Benefits shall not be provided for drugs or medicines that do not require a Physician’s prescription, vitamins (except Vitamin B-12 injections when determined to be Medically Necessary), minerals, nutritional supplements (except enteral feedings in relation to Hospice), or special diets (whether they require a Physician’s prescription or not).

See Also:
Prescription Drugs later in this section.

Occupational Therapy

Covered:
Benefits will be provided for Occupational Therapy when these services are rendered by a registered Occupational Therapist under the supervision of a Physician. This therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and Physician. The plan must be established before treatment begins and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Benefits for Occupational, Physical, and Speech Therapies will have a combined Benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CommonSpirit Facilities are not subject to this 30 visit limitation.

Not Covered:
Benefits shall not be provided for Maintenance Occupational Therapy.

See Also:
Physical Therapy later in this section.
Speech Therapy later in this section.

Office Visits

Covered:
Benefits will be provided for office visits as set forth in this section. The office visit benefit includes the consultation with a physician regarding the diagnosis and treatment of a medical condition, as well as any services bundled with the office visit claim (meaning services performed by the provider, at the provider's office and during the office visit). Office visits for preventive care (such as a routine physical) are covered as described in the Preventive or Wellness Care section.

Not Covered:
Any services that are provided by a different provider or at a different location (such as lab services, x- rays, office procedures or other ancillary charges) are not covered under the office visit benefit. These services are still covered under the Plan but will be subject to applicable Coinsurance and Deductible.

See Also:
Physicians later in this section.
Preventive or Wellness Care later in this section.
Routine Physical Exams later in this section.

Outpatient Hospital Care

Covered:
The following are examples of Covered Services when you receive them from a Hospital as an Outpatient:

- Surgery and any related Diagnostic Services received on the same day as the Surgery;
- Radiation therapy treatments;
- Chemotherapy;
- Shock therapy treatments;
- Renal Dialysis Treatments – if received in a Hospital, a Dialysis Facility, or in your home under the supervision of a Hospital or Dialysis Facility Provider;
- Diagnostic Services – when you are an Outpatient and these services are related to Surgery or Medical care;
- Emergency Accident Care;
- Emergency Medical Care; and
- Outpatient Surgery.

Outpatient Hospital care does not require pre-notification.

See Also:
Ambulance Transportation earlier in this section.
Anesthesia Services earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Chemotherapy Treatments earlier in this section.

Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Diagnostic Services earlier in this section.
Emergency Services earlier in this section.
Family Members Who Provide Services earlier in this section.
Genetic Testing earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Inpatient Hospital Care earlier in this section.
Occupational Therapy earlier in this section.
"-ologists" at Network and CommonSpirit Facilities later in this section.
Oxygen and Its Administration later in this section.
Personal Hygiene, Comfort, and Convenience Items later in this section.
Physical Therapy later in this section.
Physicians later in this section.
Pre-Admission Testing later in this section.
Preventive or Wellness Care later in this section.
Radiation Therapy Treatments later in this section.
Shock Therapy Treatments later in this section.
Speech Therapy later in this section.
Substance Use Disorder Treatment later in this section.
Surgery later in this section.
X-Ray and Laboratory Services later in this section

"-ologists" at In-Network and CommonSpirit Facilities

Covered:
When you seek Inpatient or Outpatient Hospital treatment at a CommonSpirit Facility or an In- Network Provider, Benefits for pathologists, radiologists, anesthesiologists, and emergency room specialists will be provided at the In-Network percentage level after you have met your In-Network Deductible, even if it is for an Out-of-Network Provider. However, except as otherwise required by the No Surprises Act, costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges.

Not Covered:
This does not apply to assistant surgeons.

See Also:
Anesthesia Services earlier in this section.

Optometry Services

Not Covered:
Benefits will not be provided for Optometry services under the Medical Plan. If you would like to have access to optometry services, you may elect coverage under the Vision Plan during Annual Benefit Enrollment.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses, or Cataract Lenses earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Retinal Eye Exam later in this section.
Vision Services later in this section.

Oxygen and Its Administration

Covered:
Benefits will be provided for oxygen and its administration.

Personal Hygiene, Comfort, and Convenience Items

Not Covered:
Benefits shall not be provided for personal hygiene, comfort, or convenience items commonly used for other than medical purposes, such as air conditioners, humidifiers, physical fitness equipment, televisions, and telephones.

See Also:
Inpatient Hospital Care earlier in this section.
Outpatient Hospital Care earlier in this section.
Skilled Nursing Facilities later in this section.

Physical Therapy

Covered:
Benefits will be provided for Physical Therapy when rendered by a registered professional Physical Therapist under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals.

Benefits for Occupational, Physical, and Speech Therapies will have a combined benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CommonSpirit Facilities are not subject to this 30-visit limitation.

Not Covered:
Benefits shall not be provided for Maintenance Physical Therapy.

See Also:
Occupational Therapy earlier in this section.
Speech Therapy later in this section.

Physicians

Covered:
Benefits will be provided for the following Covered Services:

- Office visits;
- Hospital visits and visits to other covered facilities;
- Physician's visits in your home;
- Surgery, whether Inpatient or Outpatient;
- Diagnostic Services;
- Medical care;
- Care for Accidental Injuries;
- Emergency Medical Care;
- Certain consultations and.
- Naturopaths in the following states due to state regulations: Alaska, Arizona, California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kansas, Maine, Maryland, Massachusetts, Minnesota, Montana, New Hampshire, New Mexico, North Dakota, Oregon, Pennsylvania, Rhode Island, Utah, Vermont, Washington, Wisconsin, US Territories: Puerto Rico and U.S. Virgin Islands.

However, the above is not an exhaustive list of the types of Covered Services and Supplies that might be provided by your Physician.

Not Covered:
Benefits shall not be covered for services provided by:

- Athletic trainers;
- Dental assistants or dental hygienists;
- Hypnotists;
- Homeopathic medical Providers;
- Priests and other religious affiliates;
- Naturopaths – any states other than those listed under covered;
- Opticians;
- Orthodontists;
- Residents, interns, or other Employees of Hospitals or Skilled Nursing Facilities who bill separately for their services and are not listed as a Provider or Professional Provider in the Glossary of Terms section of this SPD; and
- Other non-traditional medical Providers.

See Also:
Completion of Claim Forms, Reports, or Medical Records earlier in this section.
Failure to Keep a Scheduled Appointment earlier in this section.
"-ologists" at In-Network and CommonSpirit Facilities earlier in this section.
Provider or Professional Provider in the Glossary of Terms section of this SPD.

Pre-Admission Testing

Covered:
Benefits will be provided for preoperative tests given to you as an Outpatient to prepare you for Surgery which you are scheduled to have as an Inpatient, provided the Benefits would have been available to you had you received these tests as an Inpatient in a Hospital.
These tests are considered part of your Inpatient Hospital Surgical stay.

See Also:
Inpatient Hospital Care earlier in this section.
Surgery later in this section.

Prescription Drugs

Covered:
Benefits will be provided for certain Prescription Drugs or medications through the Prescription Drug Program. Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected Prescription Drugs. Benefits will be provided only if such drugs are Medically Necessary.
Prescription Drugs may be dispensed through a retail Pharmacy or the home delivery drug program.
The following are considered covered drugs under the Prescription Drug Program:

- Legend Drugs
- State restricted drugs;
- Insulin;
- Insulin needles and syringes;
- Over-the-counter diabetic supplies;
- Legend topical fluoride products;
- Retin-A (cream, gel and liquid dosage forms) and Avita for patients up to and including age 35;
- Self-administered injectables;
- Fertility medications (Limited to a lifetime maximum of $5,000 per individual);
- Contraceptive jellies, creams, foams, devices, implants, or injections (refer to Contraceptives and Contraceptive Devices section for coverage details); and
- Oral contraceptives (refer to Contraceptives and Contraceptive Devices section for coverage details).

Not Covered:
The following shall not be considered covered drugs under the Prescription Drug Program for the following:

- Non-federal legend drugs;
- Contraceptive jellies, creams, foams, devices, implants, or injections (refer to Contraceptives and Contraceptive Devices section for coverage details);
- Mifeprex (morning after pill);
- Oral contraceptives (refer to Contraceptives and Contraceptive Devices section for coverage details);
- Injectable medications (except self-administered medications);
- Insulin pumps and their supplies:
- Smoking deterrents;
- Retin-A (dosage form gel or liquid) for patients age 36 and older;
- Drugs used to treat impotency;
- Therapeutic devices or appliances (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Ostomy supplies (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Biologicals, blood, and blood plasma (not covered under the Prescription Drug Benefit but may be covered under the medical Benefits);
- Drugs whose sole purpose is to promote or stimulate hair growth;
- Drugs prescribed for cosmetic purposes;

- Drugs labeled, “Caution-limited by Federal law to Investigational use” or experimentaldrugs, even if a charge is made to the individual;
- Medication for which the cost is recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the Employee orDependent;
- Any prescription filled in excess of the number of refills specified by the Physician; or
- Any refill dispensed after one year from the Physician’s original prescription.

See Also:
Appealing a Denied Medical or Pharmacy Claim section of this SPD.
Contraceptives and Contraceptive Devices earlier in this section.
Durable Medical Equipment earlier in this section
Medical and Pharmacy Claims Procedures section of this SPD.
Network Details — Choosing a Provider section of this SPD.
Non-Prescription Drug Medications earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Smoking/Tobacco Cessation Prescription Drugs later in this section.

Preventive or Wellness Care

Covered:
Benefits will be provided for Covered Services for Preventive or Wellness Care rendered to you, even though you are not ill.

Covered services include but are not limited to the following:

- Immunizations;
- Routine history and physical examinations;
- Routine history and gynecological exams;
- Pap smears;
- Routine history and pediatric exams (well-child visits);
- Routine colonoscopies;
- Routine Preventive Care tests and laboratory screenings;
- Routine mammograms; (including Digital Breast Tomosynthesis – 3D Mammograms);
- Routine prostate tests;
- Routine vision and hearing exams, but only for newborns and Children when billed asroutine or included as part of a well Child visit;
- Counseling for tobacco cessation, weight loss and/or misuse of alcohol or drugs.

Other services may be covered based on the current recommendations of the United States Preventive Services Task Force and the Health Resources and Services Administration.

See Also:
Office Visits earlier in this section.
Routine Physical Exams later in this section.
Smoking/Tobacco Cessation Prescription Drugs later in this section.

Prosthetic Appliances and Devices

Covered:
Benefits will be provided for prosthetic devices, special appliances, and surgical implants when they are required to replace all or part of:

- An organ or tissue of the human body, or
- The function of a non-functioning or malfunctioning organ or tissue.

Benefits will also include adjustments, repairs, and replacements of covered prosthetic devices, special appliances, and surgical implants when required because of wear or change in a patient's Condition.

Not Covered:
Benefits shall not be provided for dental appliances.
Additionally, Benefits will not be provided for prosthetic devices, special appliances, and surgical implants which are for cosmetic purposes, the comfort and convenience of the patient, or unrelated to the treatment of an Illness or Accidental Injury.

See Also:
Durable Medical Equipment earlier in this section.
Foot Care and Foot Orthotics earlier in this section.
Leg, Back, Arm and Neck Braces earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Modifications to Homes, Property, or Automobiles earlier in this section.
Temporomandibular Joint Dysfunction and Related Disorders later in this section.

Radiation Therapy Treatments

Covered:
The use of Radiation Therapy Treatments to treat or control a serious Illness is covered.

Not Covered:
Benefits shall not be provided for any service that is considered Investigational as it relates to a particular Illness.

See Also:
Chemotherapy Treatments earlier in this section.
Cyber Knife Surgery earlier in this section.

Residential Treatment Facilities

Covered:
Benefits for Diagnostic Tests, X-Ray and Laboratory charges related to the residential treatment will be covered. Benefits will also be provided for room and board charges with proper prior authorization.

Not Covered:
Benefits shall not be provided for halfway houses or boarding houses.

See Also:
Mental Health Services earlier in this section.
Substance Use Disorder Treatment later in this section.

Retinal Eye Exam

Covered:
Benefits for retinal eye exams for diabetic patients.

Not Covered:
Benefits shall not be provided for non-diabetic patients.

See Also:
Diabetes Training Programs earlier in this section.
Diabetes Support Program section of this SPD.
Nephropathy Screening earlier in this section

Routine Physical Exams

Covered:
Routine physical exams are covered under preventive and Wellness Care based on the current recommendations of the United States Preventive Services Task Force and the Health Resources and Services Administration (ACA guidelines.)

See Also:
Preventive and Wellness Care earlier in this section.

Self Help Programs

Not Covered:
Benefits shall not be provided for self-help programs and self-cure products, drugs or herbal remedies.

Shock Therapy Treatments

Covered:
Benefits will be provided for shock therapy treatments.

Skilled Nursing Facilities

Covered:
Benefits will be provided for the following Covered Services when you receive them in a skilled Nursing Facility:

- Bed, board, and general nursing care; and
- Ancillary services, such as, but not limited to, drugs and surgical dressings or supplies.

Not Covered:
Benefits shall not be provided for an uncertified Skilled Nursing Facility.

See Also:
Ambulance Transportation earlier in this section.
Cardiac Rehabilitation Services earlier in this section.
Custodial Care Services earlier in this section.
Family Members Who Provide Services earlier in this section
Hearing Examinations and Hearing Aids earlier in this section.
Home Health Care earlier in this section.
Hospice Care Program Services earlier in this section.
Hospitalizations or Other Services and Supplies Which Are Not Medically Necessary earlier in this section.
Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.
Oxygen and its Administration earlier in this section.
Personal Hygiene, Comfort, and Convenience Items earlier in this section.

Sleep Apnea Treatment

Covered:
Benefits will be provided for obstructive sleep apnea diagnosis and treatments.

Not Covered:
Benefits shall not be provided for snoring without a diagnosis of obstructive sleep apnea.

Smoking/Tobacco Cessation Prescription Drugs

Covered:
Smoking/tobacco cessation prescription drugs are covered 100 percent as a preventive benefit if prescribed by a physician through the Medical Plan. You may also participate in smoking cessation support through the Wellness Program.

Not Covered:
Benefits shall not be provided for treatment or services of smoking/tobacco cessation, except as specifically provided above.

See Also:
Preventive or Wellness Care earlier in this section

Speech Therapy

Covered:
Benefits will be provided for Speech Therapy, including Speech Therapy required due to developmental delay, when these services are rendered by a licensed Speech Therapist or a Speech Therapist certified by the American Speech and Hearing Association under the supervision of a Physician. The therapy must be furnished under a written plan established by a Physician and regularly reviewed by the therapist and the Physician. The plan must be established before treatment is begun and must relate to the type, amount, frequency, and duration of therapy and indicate the diagnosis and anticipated goals. Inpatient Speech Therapy Benefits will be provided only if Speech Therapy is not the only reason for Admission.

Benefits for Occupational, Physical, and Speech Therapies will have a combined benefit limit of 30 visits per Benefit Year per covered individual. This is a combined limit between visits to In-Network and Out-of-Network Providers. CommonSpirit Facilities are not subject to this 30-visit limitation.

Not Covered:
Benefits will not be provided for Maintenance Speech Therapy.

See Also:
Occupational Therapy earlier in this section.
Physical Therapy earlier in this section.

Sterilization Procedures

Covered:
Benefits will be provided for the reversal of sterilization procedures, including reverse tubal ligations and reverse vasectomies.

Not Covered:
Benefits shall not be provided for elective sterilization procedures, including tubal ligations and vasectomies.

See Also:
Abortions earlier in this section.
Contraceptives and Contraceptive Devices earlier in this section.
Surgery later in this section.

Substance Use Disorder Treatment

Covered:
Benefits shall be provided for Covered Services for Substance Use Disorder Treatment and Substance Use Disorder Treatment Facilities.

Not Covered:
Benefits shall not be provided for halfway houses or boarding houses.

See Also:
Residential Treatment Facilities earlier in this section.

Surgery

Covered:
Benefits will be provided for Surgery performed by a Physician, Dentist, or Podiatrist. However, for services performed by a Dentist or Podiatrist, Benefits are limited to those surgical procedures which may be legally rendered by them and which would be payable under the Medical Plan had they been performed by a Physician.

Not Covered:
Benefits shall not be provided for Surgery that is not Medically Necessary, cosmetic Surgery or for weight loss Surgery that does not meet the requirements of this Plan.

See Also:
Abortions earlier in this section.
Assistant Surgeons earlier in this section.
Blood and Blood Administration earlier in this section.
Cosmetic Surgery earlier in this section.
Eligible Charges for Multiple Surgical Procedures earlier in this section.
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Human Organ Transplants earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Maternity Services earlier in this section.
Mastectomy and Related Services earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
“-ologists” at In-Network and CommonSpirit Facilities earlier in this section.
Pre-Admission Testing earlier in this section.
Sterilization Procedures earlier in this section.
Weight Loss Surgery later in this section.

Telehealth Services

Covered:
You are covered for telehealth services delivered to you by a covered practitioner acting within the scope of his or her license or certification utilizing interactive real-time audio-visual technology or web-based mobile device or similar electronic-based communication network. Services must be delivered in accordance with all applicable laws and generally accepted health care practices.

Not Covered:
Medical services provided through means other than interactive, real-time audio-visual technology, including, but not limited to, audio-only telephone, electronic mail message, or facsimile transmission.

Temporomandibular Joint Dysfunction and Related Disorders

Covered:
Benefits shall be provided for TMJ Surgery.

Not Covered:
Diagnosis and non-surgical treatment of TMJ shall not be covered under this Plan; however, it is covered under the dental plan.

Travel or Lodging Costs

Covered:
Travel and lodging costs when related to a human organ transplant, and only to the extent described as a Covered Service in the Human Organ Transplant section above.

Not Covered:
Benefits shall not be provided for travel and lodging costs except as described as a Covered Service under this Plan within this SPD.

See Also:
Ambulance Transportation earlier in this section.
Human Organ Transplants earlier in this section.

Vision Services

Covered:
Benefits will be provided for vision examinations for newborns and Children as part of a routine medical exam. Benefits will also be provided for vision examinations when related to an Accidental Injury or an Illness such as diabetes.

Not Covered:
Benefits shall not be provided for:

- Surgery to correct a refractive error (i.e., when the shape of your eye does not bend light correctly, resulting in blurred images);
- Eyeglasses or contact lenses, unless otherwise stated within this SPD, including charges related to their fitting;
- Eye exercises;
- Prescribing of corrective lenses;
- Eye examinations for the fitting of eyewear; and
- Routine vision exams, except for vision exams for newborns and Children as part of a medical exam, or when related to an Accidental Injury or an Illness such as diabetes.

See Also:
Eye Examinations and Eye-Related Diagnostic Services earlier in this section.
Eyeglasses, Contact Lenses, or Cataract Lenses earlier in this section.
Kerato-Refractive Eye Surgery earlier in this section.
Medical and Surgical Dressings, Supplies, Casts, Splints, Crutches, and Artificial Eyes earlier in this section.
Optometry Services earlier in this section.
Retinal Eye Exam earlier in this section.

Web Cam Consultations

Covered:
Web cam consultations will be covered the same as an office visit when provided by a covered Provider.

See Also:
Consultations earlier in this section.

Weight Loss Prescription Drugs

Not Covered:
Benefits will not be provided for drugs prescribed for weight loss.

Weight Loss Surgery

Covered:
For benefits to be provided, you will need to obtain pre-authorization and satisfy the criteria for surgery required by the plan as well as follow the physicians program to qualify for surgery. To learn more about the requirements for surgery, contact your medical carrier for details. Benefits are limited to one surgery per lifetime with allowance for adjustments.

Benefits will only be provided if the service is approved by the patient's health plan. The approval is valid for six months from the date of the approval. If the procedure is postponed beyond six months, the patient's health plan will need to evaluate the individual's clinical status to determine if extending the authorization timeframe is appropriate.

Not Covered:
Experimental/Investigational Weight loss surgery and Weight loss surgery that is performed without the necessary pre-authorization, including:

- Roux-en-Y gastric bypass combined with simultaneous gastric banding
- Biliopancreatic diversion (BPD) without duodenal switch (DS)
- Fobi-Pouch (limiting proximal gastric pouch)
- Gastric electrical stimulation (GES) or gastric pacing
- Gastroplasty (stomach stapling)
- Intestinal bypass
- Intragastric balloon
- Loop gastric bypass
- Mini-gastric bypass
- Vagus nerve blocking or stimulation
- Endolumenal surgery

Patients with one of the following contraindications may not be eligible for weight loss surgery.

- Severe Heart Failure
- End stage chronic lung disease
- Unstable angina (CAD)
- End stage liver disease with cirrhosis and portal hypertension
- Cancer (active under treatment or diagnosis)
- Active substance abuse/dependency (drug or alcohol)
- Major untreated psychiatric problems
- Severely impaired intellectual capacity
- Active pregnancy
- HIV/AIDs

See Also:
Surgery earlier in this section.

Wigs or Hair Pieces

Covered:
Wigs and hair pieces will be covered but only when related to hair loss resulting from medical treatment, such as Chemotherapy treatment. Coverage will be limited to one wig per year.

Not Covered:
Benefits shall not be provided for wigs and hair pieces for cosmetic purposes due to baldness or thinning of the hair, unless Medically Necessary due to medical treatment, such as for hair loss caused by Chemotherapy treatments for cancer.

See Also:
Chemotherapy Treatments earlier in this section.

Wilderness Programs

Not Covered:

Wilderness or other outdoor camps and/or programs, including:

- Lifestyle Programs. Programs to alter one's lifestyle which may include but are not limited to group socialization, behavioral modification for lifestyle enhancement, primal therapy, dance and/or music therapy, diet, exercise, weight management, outdoor skills, relaxation, recreation, imagery, or nutrition.
- Educational or Academic Services. Services, supplies or room and board for teaching, vocational, or self-training purposes. This includes but is not limited to boarding schools and/or the room and board and educational components of a program where the primary focus of the program is educational in nature rather than treatment based.
- Residential accommodations. Residential accommodations to treat medical or behavioral health conditions are not covered, except when provided in a Hospital, Hospice facility, Skilled Nursing Facility or Residential Treatment Center, and are pre-authorized as medically necessary.

This exclusion includes but is not limited to procedures, equipment, services, supplies, or charges for the following:

- Domiciliary care provided in a residential institution, treatment center, halfway house, or school because a member's own home arrangements are not available or are unsuitable, and consisting chiefly of room and board, even if therapy is included.
- Care provided or billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility home for the aged, infirmary, school infirmary, institution providing education in special environments, supervised living or halfway house, or any similar facility or institution.

X-Ray and Laboratory Services

Covered:

Tests, screenings, imaging, and evaluation procedures as identified in the American Medical Association's Current Procedural Terminology (CPT) manual, standard edition, under Radiology Guidelines and Pathology and Laboratory Guidelines.

See Also:

Diagnostic Services earlier in this section.
Inpatient Hospital Care earlier in this section.
Outpatient Hospital Care earlier in this section.
Preventive or Wellness Care earlier in this section.

The provisions in this section describe general conditions of coverage and important exclusions and limitations that apply generally to all types of services, supplies, devices, and drugs mentioned in this SPD.

General Conditions of Coverage

Medically Necessary

A key general condition for the Plan to pay Benefits is that the service, supply, device, or drug must be Medically Necessary and meet acceptable standards of medical and/or dental practices. Even a service, supply, device or drug listed as otherwise covered in *The Details — What's Covered and Not Covered* section of this SPD may be excluded if it is not Medically Necessary. The Claims Administrator determines whether a service, supply, device, or drug is Medically Necessary. Even though a Provider may recommend a service or supply, it may not necessarily be Medically Necessary

A Medically Necessary health care service is one that a Provider, exercising prudent clinical judgment, provides to a patient for the purpose of preventing, evaluating, diagnosing, or treating an Illness, Accidental Injury, disease, or its symptoms, and is:

- Provided in accordance with generally accepted standards of medical practice. Generally accepted standards of medical practice are based on:
    - Credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; and
    - Physician Specialty Society recommendations and the views of Physicians practicing in the relevant clinical area; and
    - Any other relevant factors; and
    - Clinically appropriate in terms, type, frequency, extent, site, and duration, and considered effective for the patient's Illness, Accidental Injury, or disease; and
- Not provided primarily for the convenience of the patient, Physician, or other health care Provider.

Alternative Services, Supplies, Devices, or Drugs

An alternative service, supply, device, or drug may meet the criteria of Medical Necessity for a specific Condition. If alternatives are substantially equal in clinical effectiveness and use similar therapeutic agents or regimens, the Plan reserves the right to approve the least costly alternative.

Meeting Eligibility Requirements

Another general condition of coverage is that the person who receives services must meet the eligibility requirements found in the Adding or Dropping Coverage section of this SPD and the Eligibility Addendum to this Summary Plan Description.

General Exclusions

Even if a service, supply, device, or drug is listed as otherwise covered in The Details — What's Covered and Not Covered section of this SPD, it is not eligible for Benefits if any of the following general exclusions apply:

Investigational, Experimental or Unproven Services

You are not covered for a service, supply, device, or drug that is Investigational, experimental or unproven. A treatment is considered Investigational or experimental when it has progressed to limited human applications but has not achieved recognition as being proven effective in clinical medicine.
To determine Investigational or experimental status, the Claims Administrator may refer to technical criteria established, including whether a service, supply, device, or drug meets these criteria:

- It has final approval from the appropriate governmental regulatory bodies;
- The scientific evidence must permit conclusions concerning its effect on health outcomes;
- It improves the net health outcome;
- It is as beneficial as any established alternatives; and
- The health improvement is attainable outside the Investigational settings.

While the Claims Administrator may rely on these criteria, the final decision remains at the discretion of the Plan Administrator.

Fees for Non-Medical Services
You are not covered for telephone consultations, fees for providing information concerning a Claim, charges for missed appointments, charges for completion of any form, or any other types of charges or fees for information.

Personal Hygiene, Comfort, and Convenience Items
You are not covered for items used for your personal convenience, such as:

- Items not primarily and customarily manufactured to serve a medical purpose or which can be used in the absence of Illness or Accidental Injury (including, but not limited to, air conditioners, dehumidifiers, ramps, home remodeling, hot tubs, swimming pools, etc.); or
- Items that do not serve a medical purpose or are not needed to serve a medical purpose.

Provider is a Family Member
You are not covered for a service, supply, device, or drug received from a Provider who is in your immediate family (which includes yourself, Spouse, Legally Domiciled Adult, natural or adoptive parent, Child, sibling, stepparent, stepchild, step or half-brother, step or half-sister, mother-in-law, father-in-law, son-in-law, daughter-in-law, sister-in-law, brother-in-law, grandparent, grandchild, Spouse of a grandparent, or Spouse of a grandchild).

No Payment Obligation
You are not covered for a service, supply, device, or drug for which you are not required to make payment or would have no legal obligation to pay if you did not have this Plan or similar coverage.

Covered by Other Programs or Laws
You are not covered for a service, supply, device, or drug if:

- You are entitled to claim benefits from a governmental program (other than Medicaid and, subject to the MSP requirements);
- Someone else has the legal obligation to pay for services and without this Plan, you would not be charged;
- Prescription Drug Claims submitted to the medical program Claims Administrator that were not paid by the Prescription Drug Program Claims Administrator (including amounts unpaid by the Prescription Drug Program Claims Administrator for Coinsurance and Copayments);
- Medical Claims submitted to the Prescription Drug Program Claims Administrator that were not paid by the medical program Claims Administrator (including amounts unpaid by the medical program Claims Administrator for Deductibles, Coinsurance and Copayments); and
- Services, supplies, devices, or drugs you require for an Illness or Accidental Injury sustained while on active military duty.
- Services, supplies, devices, or drugs you require for an Illness or Accidental Injury sustained while incarcerated.

Services Not Mentioned
You are not covered for any service, supply, or device that is not specifically mentioned in this SPD.

Acts of War
You are not covered for any services, supplies, devices, or drugs for any Illness or Accidental Injury occurring on or after your Coverage Date that results from war or an act of war.

Illegal Acts
Charges for services received as a result of Injury or Illness caused by or contributed to by engaging in an illegal act or occupation, by committing or attempting to commit any crime, criminal act, assault, or other felonious behavior, or by participating in a riot or public disturbance.

Workers' Compensation
You are not covered for services, supplies, devices, or drugs that are compensated under workers' compensation laws, including services, supplies, devices, or drugs applied toward satisfaction of any Deductible under your Employer's workers' compensation coverage. You are also not covered for any services, supplies, devices, or drugs that could have been compensated under workers' compensation laws if you had complied with the legal requirements relating to notice of injury, timely filing of Claims, and medical treatment authorization.

Benefit Limitations

Benefit limitations refer to amounts for which you are responsible under this Plan. These amounts are not credited toward your Out-of-Pocket Maximum. In addition to the exclusions and conditions described earlier in this section, the following are examples of Benefit limitations and your financial responsibilities under this Plan:

- A service, supply, device or drug that is not covered under this Plan is your responsibility;
- If a Spouse, parent, and/or Child are covered separately under this Plan, Benefits will not be duplicated;
- If a Covered Service, supply, device, or drug reaches a service or prescription maximum, it is no longer eligible for Benefits (a maximum may renew at the next Benefit Year). See The Details — What's Covered and Not Covered section of this SPD;
- If you receive total Benefits in an amount that reaches a Benefit or lifetime maximum, you are no longer eligible for Benefits under this Plan. See Highlights of the Medical Plan Options, Quick Reference — What's Covered and Not Covered, What You Pay — A Tutorial, and The Details — What's Covered and Not Covered sections of this SPD;
- If you do not obtain pre-notification for medical services, supplies, devices, or drugs, Benefits can be reduced or denied. You are responsible for these Benefit reductions only if you are responsible (not your Provider) for notification. An In-Network Provider may handle notification requirements for you. See Medical and Pharmacy Notification Requirements and Care Coordination;
- If you do not obtain Prior Authorization or follow Step Therapy requirements for certain Prescription Drugs, Benefits can be reduced or denied. You are responsible for any reduction in Benefits or the cost of the denied drug. See Medical and Pharmacy Notification Requirements and Care Coordination; and
- The type of Provider you choose can affect your Benefits or what you pay. See What you Pay — A Tutorial and Network Details — Choosing a Provider sections of this SPD.

Choosing Your Medical Providers

Each medical plan option under the Medical Plan has three levels of Benefits based on the type of Provider you use — CommonSpirit Facilities, In-Network Providers and Out-of-Network Providers. You will receive the highest level of Benefits at a CommonSpirit Facility.

CommonSpirit Health Facilities

CommonSpirit facilities — only charges billed on a UB Form as facility charges.
If you use a CommonSpirit Facility you will pay a lower out-of-pocket Coinsurance amount than you would for other In-Network Providers. The Plan is able to offer this richer level of Benefits because CommonSpirit Health has ownership in these facilities. Only the Facility Charges will be reimbursed at this richer Benefit level. Under the Standard Health Plan option, the Eligible Charges will not be subject to the Deductible. Under the Standard HDHP option, you must meet the Deductible before the plan begins to pay.

Professional charges billed separately by Physicians and other Providers will not be reimbursed at this richer level. However, the vast majority of these Providers will be In-Network Providers. In some instances, it might be less costly for you to travel to a CommonSpirit Facility that specializes in the type of medical care you require.

If you go to an In-Network or Out-of-Network Provider because a CommonSpirit Facility is not available, you will be reimbursed at the appropriate In-Network or Out-of-Network Provider rate and a Deductible will be applied if the Deductible has not been met and the services rendered are subject to the Deductible. To determine if a facility is a CommonSpirit Facility, call the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card.

In-Network Providers

The Plan relies on the BC/BS PPO network, which consists of Providers that have negotiated reduced rates for specific services. When these Providers offer services to you, they will not bill you for any difference between their negotiated rates (their Eligible Charges) and their standard rates. This results in lower out-of-pocket expenses for you, since the Plan will pay a higher Coinsurance level and your Deductible will be lower than if you used an Out-of-Network Provider.

To determine if a Provider is an In-Network Provider, ask your Provider, call the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card, or log on to your medical Claims Administrator's Web site, www.bcbsil.com/chi, where the In-Network Provider list is furnished automatically, without charge. See the Who to Contact With Questions section of this Summary Plan Description for the Web address.

If you are receiving Emergency Services, an Out-of-Network Provider will be treated as an In-Network Provider for the Emergency Services you receive.

Out-of-Network Providers

The Plan will also cover Out-of-Network Providers, but you will have a higher Deductible and the Plan will pay a lower Coinsurance level. You will typically pay the most for services received from them. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

If you require services from a Specialist and a Network Provider is not available within a 50-mile radius of your home address, you may utilize an Out-of-Network Specialist who has expertise in diagnosing and treating your Condition. The Claims Administrator must approve Out-of-Network Specialist services before you receive the services. Even after you receive approval, you are still responsible for complying with any notification requirements of this Plan. When approved these providers would be covered at the In-Network benefit level. In no instance will an Out-of-Network Provider ever be reimbursed at the Enhanced network rate. There will be **no exceptions** made. See the Medical and Pharmacy Notification Requirements and Care Coordination section of this SPD.

The Three Levels of Benefits Available to You

There are three types of providers and the amount you will pay out-of-pocket will vary depending on the type of provider you use.

1. **Use of a CommonSpirit Facility**

   The facility charges billed by a CommonSpirit Facility will be reimbursed at the highest percentage available under the Plan. The Eligible Charges will not be subject to the Deductible under the Standard Health Plan.

   Any Eligible Charges for services that are billed separately will be reimbursed at the appropriate In- Network or Out-of-Network Provider Coinsurance percentage. If the services rendered are subject to the Deductible and the Deductible has not been met, these charges will be applied to the Deductible.

   You will not be billed for charges above the negotiated "Eligible Charge" if the negotiated Eligible Charge is less than the actual Billed Amount.

2. **Use of an In-Network Provider**

   When you go to a BC/BS PPO In-Network Provider, you will not be billed for charges above the negotiated "Eligible Charge" if the negotiated Eligible Charge is less than the actual Billed Amount.

   You will be reimbursed at a higher percentage than if you had gone to an Out-of-Network Provider but at a lower percentage than if you had gone to a CommonSpirit Provider. If the services rendered are subject to the Deductible and the Deductible has not been met, these charges will be applied to the Deductible. If you go to an In-Network Provider because a CommonSpirit Facility is not available, you will be reimbursed at the Coinsurance percentage for Network Providers.

3. **Use of a Non-Network Provider**

   If you incur charges from an Out-of-Network Provider, the Deductible will be higher and you will be reimbursed at the lowest Coinsurance percentage level. If you go to an Out-of-Network Provider because a CommonSpirit Facility is not available, you will be reimbursed at the Coinsurance percentage for Out-of-Network Providers.

   Costs for services received from an Out-of-Network provider/facility are based on a percentage of the Medicare allowable rate for most services. In the instance Medicare has not priced a service, the pricing may be based upon a percentage of the provider's billed charges. You may be billed for the difference between the Medicare allowable rate and the provider's billed charges.

Continuity of Care

If you are under the care of an Enhanced Provider or an In-Network Provider (as described herein), who stops participating in the Plan's network (for reasons other than failure to meet applicable quality standards, including medical incompetence or professional behavior, or fraud), you may be able to elect to continue coverage for that Provider's Covered Services at the In-Network Provider Benefit level if one of the following conditions is met:

- You are undergoing a course of treatment for a serious and complex condition,
- You are undergoing institutional or inpatient care,
- You are scheduled to undergo non-elective surgery from the Provider (including receipt of postoperative care from such Provider with respect to such surgery),
- You are pregnant or undergoing a course of treatment for Your pregnancy, or
- You are determined to be terminally ill.

A serious and complex condition is one that (1) for an acute illness, is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm (for example, if you are currently receiving chemotherapy, radiation therapy, or post-operative visits for a serious acute disease or condition), and (2) for a chronic illness or condition, is (i) life-threatening, degenerative, disabling or potentially disabling, or congenital, and (ii) requires specialized medical care over a prolonged period of time.

Continuity coverage described in this provision shall continue until the treatment is complete but will not extend for more than 90 days beyond the date the Plan notifies you of the Provider's termination, or any longer period provided by

applicable law. If You are in the third trimester of pregnancy or have been determined to have a high risk pregnancy when the Provider's termination takes effect, continuity of coverage may be extended through delivery of the child, immediate postpartum care, and the follow-up check-up within the first six (6) weeks of delivery. You have the right to appeal any decision made for a request for Benefits under this provision, as explained in this Medical Plan.

You may access the Continuity of Care form at **https://www.bcbsil.com/chi/resources**. Complete the form and return it to BCBSIL for authorization to continue care with an out-of-network provider. BCBSIL may contact your provider for additional information. BCBSIL will review your document and notify you if your Continuity of Care request is approved.

Choosing a Pharmacy

When you are being treated for an Illness or Accidental Injury, your Physician may prescribe certain drugs or medicines as part of your treatment. Your coverage under the Medical Plan includes Benefits for Prescription Drugs.

You can have your prescriptions filled at a CommonSpirit Pharmacy (if available), Capital Rx network retail Pharmacy, CommonSpirit Home Delivery/90 Day Fill (if available) or through the Optum Home Delivery Pharmacy. The Prescription Drug Benefits are administered by a different Claims Administrator than your medical Benefits. For specific Copayment and Coinsurance amounts, see the Highlights of the Medical Plan section of this Summary Plan Description (SPD).

Retail Pharmacy

You will save the most money by filling your prescription at a CommonSpirit Pharmacy (if available). CommonSpirit Health also chose to offer the Pharmacy Claims Administrator's broadest network of retail Pharmacies. You are urged to check with your Pharmacy before filling a prescription to make certain that your Pharmacy is an In-Network Provider, or you may contact the Pharmacy Claims Administrator's customer service number on the back of your ID card or utilize the Pharmacy locator on their website.

To find out if your Pharmacy is an In-Network Provider or to find a Network Provider Pharmacy near you, ask your Pharmacist, call the Medical Plan Customer Service Team at the number on the back of your ID card or log on to the Pharmacy Web site. See the Who to Contact With Questions section of this Summary Plan Description for the Web address.

You may have your prescriptions filled at the Pharmacy of your choice, but your Benefits will be maximized when you use a CommonSpirit Pharmacy or a Network Pharmacy, as described below:

- When you have your prescription filled at a CommonSpirit Pharmacy, you will pay 50 percent less than you would from a Network Pharmacy.
- When you have your prescription filled at a Network Provider Pharmacy, you must pay a Copayment or Coinsurance amount for each prescription; however
- When you have your prescription filled at an Out-of-Network Provider Pharmacy, the Benefit will pay the Out-of-Network Coinsurance level of the Claims Administrator's discounted amount for that drug; you will be responsible for the remaining cost.

You can receive up to a 30-day supply of your medication at a retail Pharmacy or a 90-day supply at a CommonSpirit Pharmacy or Walgreens retail store location.

Home Delivery Pharmacy

All maintenance medications will be filled through CommonSpirit Pharmacy or Optum Home Delivery. You can receive up to a 90-day supply of your medication. Home delivery prescriptions are mailed to your home or another mailing address of your choice.

Your Medical Care

Pre-Notification

You must call the Medical Plan Customer Service Team at the number found on the back of your ID card to pre-certify the following services prior to receiving care:

- Inpatient Hospital stays;
- Room and Board for Residential Treatment;
- Private Duty Nursing Services;
- Skilled Nursing Services/Extended Care Facilities;
- Home Health Care;
- Transplants;
- Mental Health/Chemical Dependency Hospital stays (Inpatient and Partial Hospitalization Treatment Programs) and
- Weight Loss Surgery.

The following services must be pre-certified within two business days of Admission:

- Emergency Inpatient Hospital stays; and
- Maternity stays.

When you pre-certify, you should be prepared to provide the following information:

- The name of the attending and/or admitting Physician;
- The name of the Hospital where the Admission has been scheduled and/or the location where the service has been scheduled;
- The scheduled Admission and/or service date; and
- A preliminary diagnosis or reason for the Admission and/or service.

Failure to call the Medical Plan Customer Service Team or failure to comply with the determinations of the Plan will result in a $500 penalty in addition to any applicable Deductibles, Copayments and/or Coinsurance as described in this SPD. The $500 penalty does not apply for failure to pre-certify Maternity stays, which fall under the applicable 48-hour or 96-hour time frame (see Maternity Services under The Details — What's Covered and What's Not section of this SPD), or failure to pre-certify in situations where pre-notification is either impossible or would result in jeopardy to the life or health of the Claimant.

Completing the Plan's Pre-notification requirements or simply calling the Medical Plan Customer Service Team before obtaining a service acts as notice to the Plan that you are obtaining specific services, but it does not result in a guarantee of Benefits. Actual availability of Benefits is subject to eligibility and the other terms, Conditions, (including Medical Necessity), limitations, and exclusions of the Medical Plan. The decision of whether or not to receive care is between you and your Provider.

Length of Stay/Service Review

Your pre-notification notice information will be analyzed by the Plan. The Plan will review the information and any additional information they may request from you or your Provider to determine the appropriate length of stay/service for the stay/service that you have requested.

A letter will be sent by the Plan to you, your Physician and/or Hospital informing them of the appropriate length of stay/service for the stay/service you have requested.

If the Plan determines that no length of stay/service is appropriate, the Plan will notify you of its adverse Benefit determination in accordance with Notice of Adverse Benefit Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD.

Except in the case of human organ transplants, the initial length of stay/service review will not include an advance review of whether or not the underlying procedure/service is Medically Necessary. The Plan will not make its determination as to whether the underlying procedure/service is Medically Necessary until after the underlying procedure/service has been completed.

Prior Approval for Procedures/Services
The Plan will, upon request, review a proposed procedure/service for coverage under the Plan, including Medical Necessity, and give you "prior approval" before the procedure/ service is rendered. If you do not seek prior approval before undergoing a particular procedure/service, the Plan will review whether the procedure/service was properly covered under the Plan, after the fact, and if it is determined that the procedure/service was not covered by the Plan, you may be required to pay for it yourself.

You can obtain prior approval by calling the Medical Plan Customer Service Team prior to Admission or the performance of services in an Outpatient setting. You should be prepared to provide the following information:

- The name of the attending and/or admitting Physician;
- The name or description of the planned service;
- The preliminary diagnosis or reason for the Admission and/or service;
- The name of the Hospital where the Admission has been scheduled and/or the location where the service has been scheduled; and
- Scheduled Admission and/or service date.

The Plan will review the medical information provided and may follow up with your Provider to determine whether the services to be rendered are Medically Necessary and otherwise covered under the Plan. After reviewing the request, the Plan will notify you and your Provider of the decision.

- If your request is approved, you will know that the Medical Plan covers the specific services or procedures; and
- If Benefits are denied, you will receive written notice and the denial notice will list the reason(s) for denial. This notice will be mailed to the most current addresses the Plan has on record for you and your Provider.

Certain factors may alter or impact whether you receive approval. These factors include Medical Necessity, Benefit Plan provisions, and the dates you receive services.

Benefits for the approved service are limited to the Benefits described in this SPD if they are in effect for the patient on the date services are provided.

In an Emergency or Medically Urgent Situation, the Plan will respond to a request for prior approval of health services within 24 hours of the request. In non-Urgent situations, the Plan will respond to such a request within 15 days. You may appeal a denial as explained later in the Appealing a Denied Medical or Pharmacy Claim section of this SPD.

Diabetes Support Program

Taking care of yourself and your diabetes is important to your health. The Livongo for Diabetes Program, provided at no cost to you as part of the Medical Plan, offers you specialized resources and extra benefits to make managing your diabetes easier:

The Livongo connected meter, an important part of the program, helps you keep track of and manage your glucose levels by providing:

- **Unlimited free strips and lancets, plus a new free blood sugar meter:** While you are enrolled in this program, Livongo will ship the strips and lancets directly to your home, with no copays or coinsurance. You can order refills of your strips and lancets right from your Livongo meter.

- **Better diabetes monitoring:** Livongo's advanced meter uploads your readings to your private account—no more paper log books. You can track your levels, see trends and share your data with whomever you choose. The meter also provides personalized tips after each reading to support you on your diabetes management.

- **Expert support available 24/7:** Certified Diabetes Educators are available to you, on your terms. You can talk with them over the phone and from your couch about anything from nutrition to lifestyle changes. They can also reach out to you if your reading is out of range to help you when you need it most.

To get started, visit **start.livongo.com** or call the Livongo Team at (800) 945-4355. Use registration code: CHI.

Obtaining Prescriptions

Prior Authorization

The Medical Plan requires that you go through the Prior Authorization process to obtain coverage for certain Prescription Drugs. Prior Authorization is the process whereby a Pharmacist employed by the Claims Administrator approves the usage and duration of a medication. A partial list of medications that require Prior Authorization can be found below.

Your Pharmacist will inform you if the prescribed medication needs to be pre-authorized. The Pharmacist may initiate the review process, or you may request that your Physician call a toll-free phone number that will be supplied by your Pharmacist. If your medication is authorized, you will pay the applicable Copayment or Coinsurance. If your medication is not approved for coverage under the Plan, you will pay the full cost of the drug. Also, the Plan will notify you of its adverse Benefit determination in accordance with Notice of Adverse Benefit Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD.

Drugs that require Prior Authorization include but are not limited to:

- Some cancer agents;
- Rheumatoid arthritis medications; and
- Specialty medications.

This list is not intended to be all-inclusive and may be updated periodically.

Drug Utilization Review

Under the Drug Utilization Review program, prescriptions filled at the retail Pharmacy and processed on-line or through the home delivery Pharmacy are examined for potential drug interactions based on your personal medication profile. A drug interaction occurs when certain drugs act together to result in an adverse effect on the body. The Drug Utilization Review is especially important if you or your covered Dependents take many different medications or see more than one doctor. If there is a question about your prescription, your Pharmacist may contact your Physician before dispensing the medication.

Step Therapy Program

This Plan uses a tool called Step Therapy, which requires you to first try one or more specified drugs to treat a particular Condition before the Plan will cover another (usually more expensive) drug that your doctor may have prescribed. Step Therapy is intended to reduce costs to you and the Plan by encouraging use of medications that are less expensive but can still treat your Condition effectively.

Some drugs that require Step Therapy include but are not limited to:

- Migraine headache medications; and
- Proton pump inhibitors (ulcer medications).

This list is not intended to be all-inclusive and may be updated periodically.

If you are taking a medication that requires Step Therapy, the Plan will not cover that medication unless you first try the alternative (less expensive) medication. If your doctor believes you should take the original medication, your doctor can request a coverage review. If a coverage review is requested, and your Physician provides a valid clinical reason for not prescribing the alternative drug, you may purchase the originally prescribed medication at the appropriate Coinsurance. If your physician does not provide a valid clinical reason, you have the option to purchase the original medication at the full cost of the drug, or you can purchase the preferred alternative at the appropriate Copayment or Coinsurance.

Your Medical Claims

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

Once the Plan receives your Claim, it will be processed and the Benefit payment will usually be sent directly to the Hospital or Physician. You will receive an explanation of Benefits statement telling you how much was paid. In some cases, the Claims Administrator will send the payment directly to you, or, if applicable, in the case of a Qualified Medical Child Support Order, to the designated representative as it appears on the Plan's records.

Typically, you do not have to file a Claim if you use a CommonSpirit or In-Network Provider. However, in certain situations, you will have to file your own Claim, particularly if you receive care from an Out-of-Network Provider. To find out how to file a Claim, contact the Medical Plan Customer Service Team. They will provide you with Claim forms and detailed instructions.

Claims must be filed with the Claims Administrator, either by you or the Provider, on or before 12 months following the date on which your Covered Service was rendered. Claims not filed within the required time period will not be eligible for payment.

Pre-Service Claims (Prospective Review)

If you submit a Pre-Service Claim, you will be notified of the Plan's determination within 15 days of the receipt of the Claim by the Plan, unless the Plan needs an extension due to matters beyond control of the Plan and notifies you before the expiration of the initial 15-day period. The notification will include an explanation of the circumstances requiring the extension and the date by which the Plan expects to render a decision. The extension will be no longer than 15 days — that is, 30 days from the receipt of the Claim.

However, if the Plan needs an extension due to your failure to submit complete information, then the Plan will notify you of the specific information needed within 15 days of receipt of your Claim. You will have 45 days from receipt of the notice to provide the specified information.

Any notification of adverse Benefit determination will be made in accordance with Notification of Adverse Benefit Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD.

Pre-Service Claims That Are Urgent in Nature

If you submit a Pre-Service Claim that is urgent, you will be notified of the Plan's determination within 72 hours of the Plan's receipt of the Claim. Thus, in some instances, you may not receive notification prior to your scheduled date of treatment/ Admission. If you provide insufficient information for the Plan to make a determination, the Plan will notify you within 24 hours of receipt of the Claim. You will then have 48 hours to provide the missing information. The Plan will notify you of its Benefit determination within 48 hours of receiving the missing information or within 48 hours of when the information should have been provided, whichever is earlier.

Before an adverse determination may be made by the Plan, a Physician employed by the Claims Administrator will automatically review your Claim. If, after a Physician's review, an adverse determination is made, the Plan will notify you in accordance with Notification of Adverse Benefit
Determinations under the Appealing a Denied Medical or Pharmacy Claim section of this SPD. However, the Plan may notify you verbally in order to comply with the 72-hour deadline discussed above. In that event, the Plan will send a written or electronic notification within three days of the verbal notification.

Post-Service Claims

If you submit a Post-Service Claim, you will be notified of the Plan's determination within 30 days of the receipt of the Claim by the Plan, unless the Plan needs an extension due to matters beyond control of the Plan and notifies you before the expiration of the initial 30-day period. The notification will include an explanation of the circumstances requiring the extension, and the date by which the Plan expects to render a decision. The extension will be no longer than 15 days— that is, 45 days from the receipt of the Claim.

However, if the Plan needs an extension due to your failure to submit complete information, then the Plan will notify you of the specific information needed within 30 days of receipt of your Claim. You will have 45 days from receipt of the notice to provide the specified information. Otherwise, your Claim may be denied.

Any notification of adverse Benefit determination will be made in accordance with Notification of Adverse Benefit Determinations under the Appealing a denied Medical or Pharmacy Claim section of this SPD.

Payments Made in Error
If for any reason a payment is made in error, the Plan retains the right to recover the amount paid.

When Hospitalized on Your Coverage Effective Date
If you, or your enrolled Dependent, are admitted to the Hospital as an Inpatient prior to your Coverage Date, and continue to be hospitalized through your Coverage Date, the Hospital Facility Charges for that confinement will not be covered under this Plan. However, charges for Professional Provider services related to your confinement that are incurred on or after your Coverage Date will be considered for Claim Payment provided they are for Covered Services.

When Hospitalized on Your Coverage End Date
If you, or your enrolled Dependent, are admitted to the Hospital as an Inpatient prior to your coverage end date and continue to be hospitalized through your coverage end date, the Hospital Facility Charges will be covered until you are discharged from the Hospital. However, charges for Professional Provider services related to your confinement that are incurred after your coverage end date will not be covered.

Your Prescription Claims

Retail Pharmacy Claims
You can receive up to a 30-day supply of your medication at a retail Pharmacy. The Copayments or Coinsurance for retail Pharmacy prescriptions are summarized in the Highlights of the Medical Plan Options section of this SPD.

The Copayments or Coinsurance for diabetic supplies purchased at a retail Pharmacy are as follows:

- Any combination of insulin and diabetic supplies purchased on the same day are subject to one Copayment or the applicable Coinsurance amount.
- Additional Copayments or applicable Coinsurance amounts will apply to any combination of supplies (lancets, test strips, etc.) purchased separately from an insulin purchase.

Home Delivery Pharmacy Claims
You can receive up to a 90-day supply of your medication from Optum Home Delivery or CommonSpirit Home Delivery (if available). The Copayments or Coinsurance for home delivery Pharmacy prescriptions are summarized in the Highlights of the Medical Plan Options section of this SPD.

The Copayments or Coinsurance for diabetic supplies purchased through home delivery are as follows:

- Any combination of insulin and diabetic supplies purchased on the same day are subject to one Copayment or the applicable Coinsurance amount.
- Additional Copayments or applicable Coinsurance amounts will apply to any combination of supplies (lancets, test strips, etc.) purchased separately from an insulin purchase.

Benefits of Using the Home Delivery Pharmacy
Example below assumes the Deductible has been met for the Standard HDHP option and the prescription is not filled at a CommonSpirit Pharmacy.

	Generic Drug	Preferred Brand Formulary	Non Preferred Brand Non-Formulary
Standard Health Plan			
3-month supply at Optum Home Delivery	$25	$100 to $175	$160 to $325
3-month supply CommonSpirit Retail or Home Delivery	$12.50	$50 to $87.50	$80 to $162.50
Savings	$12.50	$50 to $87.50	$80 to $162.50
Standard HDHP after deductible is met			
3-month supply at Optum Home Delivery	$25	$100 to $175	$160 to $325
3-month supply CommonSpirit Retail or Home Delivery	$12.50	$50 to $87.50	$80 to $162.50
Savings	$12.50	$50 to $87.50	$80 to $162.50

Specialty Pharmacy Claims
You can receive up to a 30-day supply of your specialty medication through the CommonSpirit Specialty Pharmacy. Specialty medications treat rare or complex conditions and are typically higher cost medications. They can be an injectable, infused, oral or inhaled medication. These medications:

- May require ongoing clinical oversight and additional education for best management
- Have unique storage or shipping requirements
- May not be available at retail pharmacies
- May require special administration such as infusion or home nursing support

The Prescription Plan Formulary
The Prescription Drug portion of the Medical Plan utilizes a Formulary. A Formulary is a list of preferred drugs that have been selected based on safety, clinical effectiveness and cost effectiveness. For compound drugs, all ingredients of the compound must be included in the Formulary in order for the drug to be covered under the Medical Plan. A committee of doctors and Pharmacists reviews the Formulary semi-annually. You may purchase any covered drug, but you will pay a lower Coinsurance if you purchase drugs that are included on the Formulary. To find out if your medication is on the Prescription Plan Formulary, call Capital Rx at (844) 306-6254 or log on to www.cap-rx.com. See the Who to Contact With Questions section of this SPD.

Generic and Brand Name Drugs
All Prescription Drugs available for coverage under the Medical Plan are either Brand Name Drugs or Generic Drugs. Brand Name Drugs have the product names under which the drug is advertised and sold. Generic Drugs are sold under generic, often unfamiliar names, yet by law they must have the same active ingredients and are subject to the same rigid U.S. Food and Drug Administration (FDA) standards for quality, strength and purity as their Brand Name counterparts. You will pay a Copayment for a Generic Drug, and your out-of-pocket payment will be less.

Keep in mind, if you fill a brand-name prescription when there is a generic equivalent available, you will pay the applicable tier insurance **plus** the difference between the generic and brand-name amount. If it is Medically Necessary for you to have the brand-name prescription, your doctor can contact Capital Rx to get an exception so you don't pay more for the brand-name prescription.

How to Fill Retail Prescriptions at In-Network Pharmacies
Simply present your Medical Plan ID card and prescription(s) to the Pharmacist. The Claims Administrator's computerized system will confirm your eligibility for Benefits. The Pharmacist will tell you the Copayment or Coinsurance amount you are required to pay. You do not have to file a Claim form for prescriptions filled at an In-Network Pharmacy.

How to Fill Retail Prescriptions at Out-of-Network Pharmacies
Submit a completed Claim form to the Claims Administrator. The prescription receipt must be attached to the form. To obtain Claim forms, log on to www.cap-rx.com. (See Who to Contact With Questions) or call Capital Rx at (844) 306-6254 and use the automated ordering system.

- You must pay the full prescription price at the time of purchase

- You will be reimbursed within approximately 21 days of the Plan's receipt of your Claimform. The amount you receive will be based on the amount you would have been charged by an In- Network Pharmacy, minus the required Coinsurance amount.

How to Fill New Home Delivery Prescriptions
Ask your doctor to prescribe your medication for up to a 90-day supply plus refills (if appropriate). Contact the local CommonSpirit Pharmacy or CommonSpirit Home Delivery for the lowest cost option of filling the Home Delivery prescription. For Capital Rx's preferred home delivery pharmacy, Optum, mail your prescription and required Copayment or Coinsurance along with an order form in the envelope provided in your home delivery welcome kit. You may make payment by check or credit card. To confirm the correct Copayment or Coinsurance amount, contact Capital Rx at (844) 306-6254 or log on to www.cap-rx.com. You will receive your prescription(s) within 7-14 days at the address you indicate for delivery.

Refilling Your Home Delivery Prescriptions
You can reorder on or after the refill date indicated on the refill slip you receive with your first order, or on your medication container. You may also reorder when you have less than 14 days of medication left. For CommonSpirit Home Delivery contact the pharmacy where the prescription was filled for ordering refills. For Optum Home Delivery, you can refill your prescription on-line at **www.cap-rx.com**, or by calling Capital Rx at (844) 306-6254

How to Fill New Specialty Prescriptions
Ask your doctor to prescribe your medication for up to a 30-day supply plus refills (if appropriate). All specialty prescriptions must be processed through your local CommonSpirit Pharmacy, the CommonSpirit Specialty Pharmacy. To learn more about their services or to transfer a prescription please contact them directly.

- For CommonSpirit Health Specialty Pharmacy, call (888) 294-8348 or go to **dignityhealth.org/Arizona/locations/stjosephs/services/pharmacy.**

When you use a drug manufacturer copay card for a specialty medication, the amount actually paid by the member after the copay card is applied is the member cost share. The amount covered by the copay card will not apply to the deductible, coinsurance or out-of-pocket limits. You will still benefit from using the drug manufacturer copay card to reduce your cost share.

There may be situations that the CommonSpirit Specialty Pharmacy cannot fill your specialty medication. If that situation occurs, CommonSpirit Specialty Pharmacy will route the specialty medication prescription to Capital Rx's Specialty Pharmacy Partner.

Prescription Drug Dose Optimization
The dose optimization program helps your Physicians and Pharmacists provide the most effective and cost-efficient medication regimens. The program is designed to simplify taking prescription medications by consolidating doses.

Many prescription medications are available in a variety of strengths and can be taken safely in a single dose once a day, rather than several smaller doses throughout the day. By taking a single dose, fewer doses of the medication are required and it is more cost effective. A Pharmacist that is employed by the Claims Administrator will contact your Physician to discuss if dose optimization is right for you. Your Physician will be consulted before any change is made to your prescription.

Prescription Drug Quantity Limitations
Some medications are covered only in certain quantities. In addition, the covered quantity amount may be limited to certain time periods. The limits on these medications are based on treatment guidelines that are considered reasonable, safe, and effective. However, in cases where your prescription exceeds the quantity limit and additional quantities might be Medically Necessary, your Physician must provide additional medical information to the Plan to determine whether the particular circumstances meet the criteria for additional quantities.

Benefits for Medicare Eligible Covered Persons

This section describes the Benefits which will be provided for Medicare Eligible Covered Persons who are not affected by Medicare Secondary Payer (MSP) laws, (see Medicare Eligible Persons and Their Enrollment in This Plan and Your Medicare Secondary Payer (MSP) Responsibilities under the Adding or Dropping Coverage section of this SPD).

The Benefits and provisions described throughout this Summary Plan Description (SPD) apply to Medicare Eligible Covered Persons. The process used in determining Benefits under the Medical Plan is as follows:

- Determine what the payment for a Covered Service with provisions of the Plan; and
- Process and make payment based on the type of service received and benefit level of the provider.

Coordination of Benefits

Coordination of Benefits (COB) applies when you or your Dependents have health care coverage through more than one group program. The intent of COB is to provide that the sum of Benefits paid under the Medical Plan plus Benefits paid under all other plans will not exceed the actual cost charged for treatment. If the Medical Plan Benefit amount is greater than the primary carrier's payment, the Medical Plan will pay the difference between its Benefit and the primary carrier's payment. If it is less than or equal to the primary carrier's payment, the Medical Plan will pay nothing. It is your obligation to notify the Medical Plan Customer Service Team of the existence of such other Group Coverage.

To coordinate Benefits, it is necessary to determine what the payment responsibility is for each Benefit program. This is done by following the rules below:

- The coverage under which the patient is the Eligible Person (rather than a Dependent) is primary, meaning: full Benefits are paid under that program. The other coverage is secondary and only pays any remaining Eligible Charges up to the Benefits available under that program.
- When a Dependent Child receives services and the Child is covered under more than one parent's health care plan, the birthdays of the Child's parents are used to determine which coverage is primary. The coverage of the parent whose birthday (month and day) comes before the other parent's birthday in the calendar year will be considered the primary coverage. If both parents have the same birthday, then the coverage that has been in effect the longest is primary. If the other coverage does not have this "birthday" type of COB provision and, as a result, both coverages would be considered either primary or secondary, then the provisions of the other coverage will determine which coverage is primary.
- However, when the parents are separated or divorced and the parent with custody of the Child has not remarried, the Benefits of a program which covers the Child as a Dependent of the parent with custody of the Child will be determined before the Benefits of a program which covers the Child as a Dependent of the parent without custody;
    - When the parents are divorced and the parent with custody of the Child has remarried, the Benefits of a program which covers the Child as a Dependent of the parent with custody will be determined before the Benefits of a program which covers that Child as a Dependent of the step-parent, and the Benefits of a program which covers that Child as a Dependent of the stepparent will be determined before the Benefits of a contract which covers that Child as a Dependent of the parent without custody; and
    - Notwithstanding the items above, if there is a court decree which would otherwise establish Financial Responsibility for the medical, dental, or other health care expenses with respect to the Child, the Benefits of a program which covers the Child as a Dependent of the parent with such Financial Responsibility shall be determined before the Benefits of any other program which covers the Child as a Dependent Child. It is the obligation of the person claiming Benefits to notify the Medical Plan, and upon its request to provide a copy of such court decree.
    - If neither of the above rules apply, then the coverage that has been in effect the longest is primary.

The only time these rules will not apply is if the other group Benefit program does not include a COB provision. In that case, the other group program is automatically primary.

Additionally, in the case of the removal of impacted wisdom teeth or for oral Surgery, a patient's dental plan (if any, and if the above procedure is listed as a covered Benefit under that plan) will always be primary, and the Medical Plan will be secondary. If there is no dental coverage, the Medical Plan will be primary.

The Medical Plan has the right in administering these COB provisions to:

- Pay any other organization an amount which it determines to be warranted if payments which should have been made by the Medical Plan have been made by such other organization under any other group program; and
- Recover any overpayment which the Medical Plan may have made to you, any Provider, insurance company, person or other organization.

In order to prevent duplicate payment of Benefits for a Claim, the Medical Plan uses the following process to determine Benefits when it is the secondary payor:

- Determine what the Benefit for services would be under the provisions of the Medical Plan; and
- Deduct from this resulting amount the amount paid by the primary payor. The difference is the Benefit that will be paid under the Medical Plan.

Rights to Reduction, Reimbursement, and Subrogation

The Medical Plan has the right to:

- Reduce or deny Benefits otherwise payable by the Medical Plan; and
- Recover or subrogate 100 percent of the Benefits paid by or to be paid by the Medical Plan for covered persons to the extent of any and all of the following payments:
    - Any judgment, settlement or payment made or to be made because of an Accident, including but not limited to other insurance;
    - Any auto or recreational vehicle insurance coverage or Benefits including but not limited to uninsured/ underinsured motorist coverage;
    - Any personal umbrella coverage;
    - Any medical payments coverage, no fault automobile coverage or any first party insurance coverage;
    - Business and homeowners medical and/or liability insurance coverage or payments;
    - Workers' Compensation coverage;
    - Attorney's fees; and
    - Any other coverage available for your illness or injury.

Subrogation

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

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

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

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

Reimbursement

If you receive any payment as a result of an injury, illness or condition, you agree to reimburse the plan first from such payment for all amounts the plan has paid and will pay as a result of that injury, illness or condition, up to and including the full amount of your recovery.

Cooperation Required

The Medical Plan requires covered persons or their representatives to cooperate in order to guarantee reimbursement to the Medical Plan from any other party Benefits. It is your duty to notify the Plan within 30 days of the date when any notice is given to any party, including an insurance company or attorney, your intention to pursue or investigate a claim to recover damages or obtain compensation due to your injury, illness or condition. Failure to comply with this request will

entitle the Plan to withhold Benefits due to covered persons under the Medical Plan. Covered persons or their representatives may not do anything to hinder reimbursement of overpayment to the Medical Plan after you have accepted Benefits.

All attorney's fees and court costs are the responsibility of the Participant, not the Medical Plan. These rights apply regardless of whether such payments are designated as payment for, but not limited to:

- Pain and suffering;
- Medical Benefits;
- Other specified damages; or
- Whether the Participant has been made whole (i.e., duly compensated for his/her injuries).

The Plan has the right to file suit on your behalf for the Condition related to the medical expenses to recover Benefits paid or to be paid by the Medical Plan.

Additional Provisions

The following provisions also apply:

- If you reside in a state where automobile personal injury protection or medical payment coverage is mandatory, that coverage is primary and the Medical Plan is secondary. The Medical Plan will reduce Benefits for an amount equal to, but not less than, the state's mandatory minimum personal injury protection or medical payment requirement;
- The Medical Plan has first priority with respect to its right to reduction, reimbursement and subrogation;
- The Medical Plan is secondary to any excess insurance policy, including but not limited to, school and/or athletic policies;
- The Medical Plan has the right to reduce or withhold future Benefits payments for Claims filed for covered persons;
- The Medical Plan will not pay for future medical charges because of the Accident until medical charges have exceeded all amounts that were recovered, or are to be recovered by or on behalf of the covered person;
- The provisions described in the Rights to Reduction, Reimbursement, and Subrogation under this section of the SPD apply to you and all of your covered Dependents;
- The Medical Plan has the right to recover interest on the amount paid out by the Plan because of the Accident;
- The Medical Plan has the right to recover the amount paid out because of the Accident in a lump sum;
- The Medical Plan is not subject to any state law doctrines, including but not limited to the common fund doctrine, which would purport to require the Medical Plan to reduce its recovery by any portion of a covered person's attorney's fees and costs;
- The Plan does not pay for nor is responsible for the covered person's attorney's fees. Attorney's fees are to be paid solely by the covered person;
- The right of reduction, reimbursement, and subrogation is based on the language in the Summary Plan Description in effect at the time of judgment, payment or settlement;
- The Medical Plan's right of reduction, reimbursement and subrogation applies to any funds recovered from another party by or on behalf of the estate of any covered person; and
- The Medical Plan's right to first priority shall not be reduced due to the Eligible Person's own negligence.
- By accepting benefits (whether the payment of such benefits is made to you or made on your behalf to any provider) you agree that if you receive any payment as a result of an injury, illness or condition, you will serve as a constructive trustee over those funds. Failure to hold such funds in trust will be deemed a breach of your fiduciary duty to the plan;
- Further, the Plan will automatically have a lien to the extent of Benefits paid by the Plan for the treatment of the illness, injury or condition upon any recovery whether by settlement, judgment or otherwise, related to treatment for any illness, injury or condition for which the plan paid Benefits. The lien may be enforced against any party who possesses funds or proceeds representing the amount of benefits paid by the plan including, but not limited to, you, your representative or agent, and/or any other source possessing funds representing the amount of benefits paid by the Plan;
- In order to secure the Plan's recovery rights, you agree to assign to the Plan any benefits or claims or rights of recovery you have under any automobile policy or other coverage, to the full extent of the Plan's subrogation and reimbursement claims. This assignment allows the Plan to pursue any claim you may have, whether or not you choose to pursue the claim.

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

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

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

Your Responsibility Regarding Right of Reduction and/or Recovery
To aid the Medical Plan in its enforcement of its right of reduction, recovery, reimbursement and subrogation, the Eligible Person and his/her representative must, at the Medical Plan's request and at its discretion:

- Take any action;
- Give information; and
- Execute documents so required by the Medical Plan.

Failure to aid and comply with such requests may result in the Medical Plan withholding or recovering Benefits, services, payments or credits due or paid under the Medical Plan.

The Medical Plan's right to reimbursement occurs when the Medical Plan pays your charges relating to an Accident while waiting for any party to make payment to you or to someone else on your behalf.
Reimbursement to the Medical Plan of 100 percent of these charges shall be made at the time the payment is received by you, your attorney or other person on your behalf.

Appealing an Eligibility Claim

If you are denied a Benefit under the Plan due to questions regarding your eligibility or entitlement for coverage under the Plan or regarding the amount you owe, you may request a review upon written application to the Plan Administrator. You, or your authorized representative, may request access to all relevant documents in order to evaluate whether to request review of an adverse benefits determination and if review is requested, to prepare for such review.

Your first level appeal of an adverse benefits determination based on eligibility or entitlement to coverage under the Plan must be made in writing within 180 days upon receipt of the notice that the eligibility claim was denied. If your first level appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited.

A written appeal should include: written description of the reason for the appeal, written comments, additional documents and any other information in support of the appeal. The review of the adverse benefits determination will take into account all new information, whether or not presented or available at the initial determination. No deference will be afforded to the initial determination.

The Plan Administrator, within a reasonable time, but no later than 60 days after receipt of the request for review, will decide the appeal. Once a decision is reached, a letter providing notice of the decision will be provided which sets forth:

- The specific reasons for the decision on review;
- The specific Plan provisions on which the decision is based;
- A statement regarding the right to review, upon request and at no charge, relevant documents and other information.

If an “internal rule, guideline, protocol, or other similar criterion” is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge upon request.

In the event that you disagree with the Plan Administrator’s decision, you may file a second level appeal in writing within 180 days of receipt of the Plan Administrator’s decision. If your second level appeal is not made within the above referenced timeframe, all rights to appeal the adverse benefits determination and to file suit in court will be forfeited. The written appeal should include: written description of the reason for the appeal, written comments, additional documents and any other information in support of the appeal.

Your second level appeal will be conducted by the CommonSpirit Health & Welfare Benefits Appeals Committee (the “Committee”), who is neither the individual who made the initial benefit determination nor a subordinate of such individual. The Committee will make a full and fair review of your request and may ask for additional information. The Committee’s review of the previously denied appeal will not afford that denial any deference. The Committee will provide you notice of the Plan’s final decision within 60 days of the Committee’s receipt of your second level appeal.

Exhaustion of Administrative Remedies

The exhaustion of the above appeal procedures is mandatory for resolving every eligibility or entitlement to coverage claim or dispute arising under this Plan. Only after you have exhausted the above appeal procedures can you bring a civil action for a denied claim.

Limitations Period

If you have complied with and exhausted the appeals procedures described above and intend to exercise your right to bring a civil action under ERISA, you must bring such action within 12 months of the date that the final decision has been rendered denying your claim. If you do not bring such action within 12 months of this date, you shall be barred from bringing an action under ERISA related to your claim.

Adverse Benefits Determinations

If the Plan makes an adverse Benefit determination, you will receive a written or electronic notice from the Plan with:

- Specific reasons for denial;
- Reference to the Plan provisions on which the denial is based;
- Description of additional information which may be necessary to clarify your Claim and an explanation as to why the information is necessary;
- Explanation of how you may have the Claim reviewed, including applicable time limits and a statement of your right to bring a civil action following an adverse determination or review. Please note, however, that civil action will not be an option until the first mandatory appeal is completed.
- Also, if a specific internal rule, guideline, protocol, or other similar criterion was relied upon in making the adverse determination, the Plan will provide a copy of the rule, guideline, protocol, or other similar criterion or a statement will be provided stating that such an item was used in making the determination and that a copy of it will be sent upon request.

If the adverse determination is based on a Medical Necessity exclusion, Investigational or experimental treatment exclusion, or a similar exclusion or limit, then an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your medical circumstances will be provided, or a statement will be provided stating that such analysis will be provided upon request. If you receive an adverse determination concerning a Claim for an Emergency or Medically Urgent Situation, you will also receive a description of the expedited review process available for such a Claim.

Appeal Process for Medical Claims

If you have questions regarding coverage or how a Claim will be paid, you should call the Medical Plan Customer Service Team at the toll-free telephone number listed on the back of your ID card. If, after your Claim is processed, you question the payment of a Claim, you may submit an appeal for review. The appeals process varies slightly depending on whether the Claim is for Prescription Drug Benefits or for other Benefits within the Plan. The Prescription Drug Benefit appeals process is described later in this section. See Appeal Process for Prescription Drug Claims.

The review process will be conducted by someone different from the original decision makers and without deference to the original decision. If a decision requires medical judgment, an appropriate medical expert will be consulted who was not previously involved in your case. If the decision on an appeal is adverse, you may request in writing the identity of the medical expert who was consulted.

Post-Service Claim Appeals Process

Before beginning the appeals process, you may wish to call the Medical Plan Customer Service Team. They may be able to assist you. However, any communication and/or correspondence exchanged with the Customer Service Team will not affect your appeals deadlines as set forth in this Summary Plan Description. You must comply with these deadlines.

STEP ONE – Appeal to the Claims Administrator

If your Claim has been denied in whole or in part, you may have your Claim reviewed. The Claims Administrator will review its decision in accordance with the following procedure:

- Notify the Claims Administrator of the reasons why you do not agree with the denial orpartial denial;
- Provide any clinical documentation from your Physician that would substantiate coverageof the denied Claim;
- Include the following information:
    - Name;
    - Address;
    - Daytime Phone Number;
    - Group and ID Number; and
    - Provider Name and Date of Service; and
- File the Claim within 180 days after you receive notice of a denial or partial denial by submitting the appeal to the Claims Administrator either in writing or by calling the CHI Medical Plan Customer Service Team.

Written appeals should be sent by U.S. mail to:

The Medical Plan
Blue Cross Blue Shield of Illinois
Attn: Appeals Department
3405 Liberty Drive
Springfield, IL 62704

You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

The Claims Administrator will give you a written decision within 60 days after it receives your request for review. The receipt of the Claims Administrator's written decision marks the end of your official appeal. If the determination is unfavorable to you, you may submit a voluntary request for review to the Plan Administrator, as discussed below.

STEP TWO – Voluntary Request for Review
If the appealed claim is again denied, you may file a second appeal with the Claims Administrator. The denial notice will specify the timeframe for filing a second appeal (typically 60 days from receipt of the denial notice). You also have the right to request without charge, copies of any document, record or other information submitted, considered, generated or used in making the decision.

Notice of the second appeals decision will be sent to you within 60 days of receipt of the appeal.

If your appeal is denied, you may have the right to file a request for an external review of the adverse benefits determination. A denial, reduction, termination or failure to provide a benefit based on a determination that a participant or beneficiary fails to meet the eligibility requirements under the terms of the Plan is not eligible for external review. Please contact the Claims Administrator for additional information on requesting an external review.

If you have complied with and exhausted the appeals procedures described above and intend to exercise your right to bring a civil action under ERISA, you must bring such action within 12 months of the date that the final decision has been rendered denying your claim. If you do not bring such action within 12 months of this date, you shall be barred from bringing an action under ERISA related to your claim.

Pre-Service Claim Appeals Process

If you have a pre-service request that has been denied, you are entitled to an expedited review process. Start your expedited review appeal by calling the Medical Plan Customer Service Team. They may be able to assist you. However, any communication and/or correspondence exchanged with the Customer Service team will not affect your appeals deadlines as set forth in this Summary Plan Description. You must comply with these deadlines.

STEP ONE – Appeal to the Claims Administrator
Within 180 days after you receive notice of a denial or partial denial, you may submit an appeal to the Claims Administrator either in writing or by calling the Medical Plan Customer Service Team. The Claims Administrator will need to know the reasons why you do not agree with the denial or partial denial. You should include any clinical documentation from your Physician that would substantiate coverage of the denied Claim. The appeal must include the following information:

- Name;
- Address;
- Daytime Phone Number;
- Group and ID Number; and
- Provider Name and Date of Service.

Written appeals should be sent by U.S. mail to the same address listed above under Post-Service Claim Appeals Process for step one appeals to the Claims Administrator.

You may designate a representative to act for you in the review procedure. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative. When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.

Medically Urgent Pre-Notification Request
If you seek pre-notification for a Medically Urgent Situation and receive an adverse Benefit determination, you are entitled to a review of the adverse determination within 72 hours of the Claims Administrator's receipt of your appeal. If the resolution of your official Medically Urgent Situation pre-notification request appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

Non-Urgent Pre-Service Requests
If you seek a non-Urgent pre-service request and receive an adverse Benefit determination, you are entitled to a review of the adverse determination within 30 days of the Claims Administrator's receipt of your request for appeal. If the resolution of your official Pre-Service Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

If the determination is unfavorable to you, you may submit a voluntary request for review to the Plan Administrator, as discussed later in this section.

STEP TWO – Voluntary Request for Review for Both Pre-Service and Post-Service Claims
If the appealed claim is again denied, you may file a second appeal with the Claims Administrator. The denial notice will specify the timeframe for filing a second appeal (typically 60 days from receipt of the denial notice). You also have the right to request without charge, copies of any document, record or other information submitted, considered, generated or used in making the decision.

Notice of the second appeals decision will be sent to you within 60 days of receipt of the appeal.

If your appeal is denied, you may have the right to file a request for an external review of the adverse benefits determination. A denial, reduction, termination or failure to provide a benefit based on a determination that a participant or beneficiary fails to meet the eligibility requirements under the terms of the Plan is not eligible for external review. Please contact the Claims Administrator for additional information on requesting an external review.

If you have complied with and exhausted the appeals procedures described above and intend to exercise your right to bring a civil action under ERISA, you must bring such action within 12 months of the date that the final decision has been rendered denying your claim. If you do not bring such action within 12 months of this date, you shall be barred from bringing an action under ERISA related to your claim.

External Review
"External Review" is a review of an eligible adverse benefit determination or a final internal adverse benefit determination by an independent review organization/external review organization (ERO) or by the State Insurance Commissioner, if applicable. A "final external review decision" is a determination by an ERO at the conclusion of an external review.

You must complete all of the levels of standard appeal described above before you can request external review, other than in a case of deemed exhaustion. Subject to verification procedures that the Plan may establish, your authorized representative may act on your behalf in filing and pursuing this voluntary appeal. You may file a voluntary appeal for external review of any adverse benefit determination or any final internal adverse benefit determination that qualifies as set forth below.

The notice of adverse benefit determination or final internal adverse benefit determination that you receive will describe the process to follow if you wish to pursue an external review. You must submit the request for external review within 180 calendar days of the date you received the adverse benefit determination or final internal adverse benefit determination notice. If the last filing date would fall on a Saturday, Sunday or federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday or federal holiday. You also must include a copy of the notice and all other pertinent information that supports your request.

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

Request for External Review
The external review process under this Plan gives you the opportunity to receive review of an adverse benefit determination (including a final internal adverse benefit determination) conducted pursuant to applicable law. Your request will be eligible for external review if the claim decision involves medical judgment and the following are satisfied:

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

An adverse benefit determination based upon your eligibility is not eligible for external review. If upon the final standard level of appeal, the coverage denial is upheld and it is determined that you are eligible for external review, you will be informed in writing of the steps necessary to request an external review.

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

If you have complied with and exhausted the appeals procedures described above and intend to exercise your right to bring a civil action under ERISA, you must bring such action within 12 months of the date that the final decision has been rendered denying your claim. If you do not bring such action within 12 months of this date, you shall be barred from bringing an action under ERISA related to your claim.

Appeal Process for Prescription Drug Claims
If Prior Authorization of your Prescription Drug is denied, use the following steps:

STEP ONE – Initial Appeal to the Claims Administrator
Within 180 days after you receive notice of a denial or partial denial, forward your appeal to the Claims Administrator. The appeal must be in writing and must include the following information:

- Name;
- Address;
- Daytime Phone Number;
- Group and ID Number; and
- Provider Name and Date of Service
- A clear statement that the communication is intended to appeal an Adverse Benefit Determination or Adverse Coverage Determination

The appeal should be sent by U.S. mail or fax to:

Capital Rx
Attention Appeals Department
9450 SW Gemini Dr., #87234
Beaverton, OR 97008
Phone: (888) 832-2779
Fax: (833) 434-0563

You may designate a representative to act for you in the review process. Your designation of a representative must be in writing as it is necessary to protect against disclosure of information about you except to your authorized representative.

When you are preparing your appeal, you and/or your authorized representative may ask to see relevant documents and may submit written issues, comments and additional medical information within 180 days after you receive notice of a denial or partial denial.
The Claims Administrator will give you a written decision within 30 days after it receives your request for review.

Expedited Review Processes Available for Pre-Notification Claims
If you seek review of a Medically Urgent Situation Claim or Pre-Service Claim that has been denied, and you do not purchase the drug due to its expense, then you are entitled to an expedited pre-service review within 30 days of the Claims Administrator receiving your Claim.
Use the same procedures set forth above in the Appeal Process for Prescription Drug Claims section above.

Medically Urgent Situation Claims
If you seek Prior Authorization for a Prescription Drug that is needed urgently and your request for Prior Authorization is denied, the Claims Administrator will review the adverse determination within 72 hours of their receipt of your request for review. If the resolution of your official Medically Urgent Situation Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

Pre-Service Claims
If you seek Prior Authorization for a drug, you are denied, and you do not purchase the drug due to its expense, then you are entitled to an expedited pre-service review within 15 days of the Claims Administrator receiving your Claim. Additionally, your second request for review by the Claims Administrator will also be completed within 15 days of their receipt of your second request for review. If the resolution of your official Pre-Service Claim appeal is unfavorable to you, then you may submit a voluntary request for review to the Claims Administrator. If you have exhausted your appeal rights, you may pursue legal remedies.

If you have complied with and exhausted the appeals procedures described above and intend to exercise your right to bring a civil action under ERISA, you must bring such action within 12 months of the date that the final decision has been rendered denying your claim. If you do not bring such action within 12 months of this date, you shall be barred from bringing an action under ERISA related to your claim.

Termination of Coverage

Coverage under this plan will cease on the last day of the month in which one or more of the following occur:

- You no longer meet the description of an Eligible Person;
- The Medical Plan terminates; or
- Your Dependent ceases to be eligible for enrollment as a covered Dependent under the rules set forth in the Adding or Dropping Coverage and Glossary of Terms sections of this Summary Plan Description (SPD).
- You or your Dependents commit a fraud or intentional misrepresentation on the Plan.

No Benefits are available to you for services or supplies rendered after the date of termination of your coverage under this Plan, except as otherwise specifically stated in the Continuation of Coverage (COBRA) section below. However, termination of your coverage under the Medical Plan shall not affect any Claim for Covered Services rendered prior to the Effective Date of such termination.

If one of your Dependents becomes ineligible, his or her coverage will end as of the last day of the month in which the Qualified Life Event occurs which makes him or her ineligible (for example, date of marriage, date of divorce, date the limiting age is reached). Options available for continuation of coverage are explained in the Continuation of Coverage (COBRA) section below.

Continuation of Coverage (COBRA)

The purpose of this section of the Summary Plan Description is to explain the options which are required under the Consolidated Omnibus Budget Reconciliation Act of 1985 which is a federal law for temporarily continuing your coverage at group rates in certain instances when your coverage would otherwise end.

Introduction

This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. **This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.**

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description (SPD) or contact the Plan Administrator.

Note: Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about Health Insurance Marketplace options at **www.healthcare.gov.**

What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your Spouse/Legally Domiciled Adult and your Dependent Children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

If you are the Spouse/Legally Domiciled Adult of an Employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your Spouse/Legally Domiciled Adult dies;

- Your Spouse/Legally Domiciled Adult's hours of employment are reduced;
- Your Spouse/Legally Domiciled Adult's employment ends for any reason other than his or her gross misconduct.;
- Your Spouse/Legally Domiciled Adult becomes entitled to Medicare Benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your Spouse.

Your Dependent Children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:
The parent-Employee dies;

- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct.;
- The parent-Employee becomes entitled to Medicare Benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The Child is no longer eligible for coverage under the Plan as a "Dependent Child."

When is COBRA Coverage Available?
The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the Employee, or the Employee becoming entitled to Medicare Benefits (under Part A, Part B, or both), the Employer must notify the Plan Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events
For other qualifying events (such as: divorce or legal separation of the Employee and Spouse or a Dependent Child's losing eligibility for coverage as a Dependent Child), you must notify the Plan Administrator within 60 days after the qualifying event occurs.

You must provide this notice to the contact provided at the end of this section.

Notification of a qualifying event to the Plan Administrator must include the following information:

- Name and identification number of the Member and each qualified beneficiary;
- Type and date of initial or second qualifying event; and Name, address and daytime phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed to determine COBRA rights.

How is COBRA Coverage Provided?
Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their Spouses, and parents may elect COBRA continuation coverage on behalf of their Children.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the Employee, the Employee becoming entitled to Medicare Benefits (under Part A, Part B, or both), your divorce or legal separation, or a Dependent Child losing eligibility as a Dependent Child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the Employee's hours of employment, and the Employee became entitled to Medicare Benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the Employee lasts until 36 months after the date of Medicare entitlement.

For Example: If a covered Employee becomes entitled to Medicare eight months before
the date on which his or her employment terminates, COBRA continuation coverage for his or her Spouse and Children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the Employee's hours of employment, COBRA continuation coverage generally lasts for up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension of 18-Month Period of Continuation Coverage
If you or anyone in your family covered under the Plan is determined by the Social Security Administration (SSA) to be disabled and you notify the Plan Administrator within 60 days of the Social Security Administration's decision (and before the end of the original 18-month period of COBRA continuation coverage), you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

To request an extension of your continuation coverage due to disability, send a copy of any letters from the Social Security Administration and the Notice of Determination to the contact provided at the end of this section. Your request must also include the following:

- Name and identification number of the member and each qualified beneficiary;
- Type and date of initial or second qualifying event;
- Phone number of the qualified person (or legal representative) that the Plan Administrator may contact if additional information is needed to determine COBRA rights.

Second Qualifying Event Extension of 18-Month Period of Continuation Coverage
If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the Spouse and Dependent Children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the Plan. This extension may be available to the Spouse and any Dependent Children receiving continuation coverage if the Employee or former Employee dies, becomes entitled to Medicare Benefits (under Part A, Part B, or both), or gets divorced or legally separated, or if the Dependent Child stops being eligible under the Plan as a Dependent Child, but only if the event would have caused the Spouse or Dependent Child to lose coverage under the Plan had the first qualifying event not occurred.

Determining Your Contributions for Continuation Coverage
Your contributions are regulated by law, based on the following:

- For the 18 or 36-month periods, contributions may never exceed 102 percent of the plan costs.
- During the 18 through 29-month period, contributions for coverage during the extended disability period may never exceed 150 percent of the plan costs.

If You Have Questions
Questions concerning your Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under ERISA, including COBRA, the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA Web site at http://www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site.)

Keep Your Plan Informed of Address Changes
In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

Plan Contact Information
Human Resources – Sisters of Charity, Cincinnati

Continuation of Coverage Under USERRA:

USERRA provides for continuation of health care coverage if you are called for active duty military service.

The maximum length of extended coverage under USERRA is the lesser of:

- 24 months beginning on the date that the military leave begins; or
- A period beginning on the day that the leave began and ending on the day after your reemployment application deadline.

If your military leave does not exceed 31 days, you will not be required to pay more than your share of the premium toward the extended coverage. If the leave is 31 days or more, then you will be required to pay the full premium cost, plus an additional 2% administration fee.

If you return to covered employment after a military leave has ended, your medical coverage will be reinstated. You will not have to provide proof of good health or satisfy any waiting periods that might otherwise apply. However, exclusions or limitations may apply to an illness or injury (as defined by the Veterans Administration) incurred as a result of the military service.

Your COBRA continuation coverage and USERRA continuation coverage are concurrent.

Family Medical Leave (FMLA)

If CommonSpirit Health grants you an approved family or medical leave (approved FMLA leave) leave for a period in excess of the period required by FMLA, any continuation of coverage during that excess period will be determined by CommonSpirit Health in accordance with the applicable leave of absence policy.

If CommonSpirit Health grants you an approved FMLA leave in accordance with FMLA, you may, during the continuance of such approved FMLA leave, continue all health Benefits for you and your eligible Dependents. Alternatively, if your approved FMLA leave is unpaid, you may choose to discontinue all coverage under the Plan during your FMLA leave. If you choose to continue all coverage during your FMLA leave, at the time you request the leave, you must agree to make any required contributions to continue all coverage. If any coverage CommonSpirit Health allows you to continue has reduction rules applicable by reason of age or retirement, the coverage will be subject to such rules while you are on FMLA leave.

Unless you return to work on or prior to the following, coverage will not be continued beyond the first to occur of:

- The date you are required to make any contribution and you fail to do so. *
- The date CommonSpirit Health determines your approved FMLA leave is terminated.
- The date the coverage involved discontinues. However, health coverage may be available to you under another plan sponsored by CommonSpirit Health.

* If you return to work for CommonSpirit Health after your approved FMLA leave is terminated, your coverage will be reinstated under the Plan on the same terms as before the FMLA leave began (subject to any changes in benefit levels). If you do not immediately return to work, you will be eligible for COBRA or other group health continuation coverage as applicable.

Any coverage being continued for a Dependent will not be continued beyond the date it would otherwise terminate. If Benefits terminate because your approved FMLA leave is deemed terminated (but you do not immediately return to work), you may, on the date of such termination, be eligible for COBRA or other group health continuation coverage as applicable on the same terms as though your employment terminated on such date. If this Plan provides any other continuation of coverage (for example, upon termination of employment, death, divorce or ceasing to be a defined Dependent), you (or your eligible Dependents) may be eligible for such continuation on the date CommonSpirit Health determines your approved FMLA leave is terminated or the date of the event for which the continuation is available.

If you acquire a new Dependent while your coverage is continued during an approved FMLA leave, the Dependent will be eligible for COBRA or other group health continuation coverage as applicable on the same terms as would be applicable if you were actively at work, not on an approved FMLA leave.

If you return to work for CommonSpirit Health following the date CommonSpirit Health determines the approved FMLA leave is terminated, your coverage will be reinstated under the Plan on the same terms as before the FMLA leave began (subject to any changes in benefit levels).

If any coverage being continued terminates because CommonSpirit Health determines the approved FMLA leave is terminated, you will be eligible for COBRA or other group health continuation coverage as applicable on the date CommonSpirit Health determines the approved FMLA leave is terminated.

Consolidated Appropriations Act

Notwithstanding anything in this SPD to the contrary, the Plan shall be administered consistent with the Consolidated Appropriations Act, 2021, including but not limited to the provisions of the No Surprises Act (collectively, the "Act"). Any and all terms of this SPD shall be interpreted consistent with the Act and any regulatory guidance issued thereunder.

For the purposes of this SPD, to the extent any terms are utilized to reflect special rules or provisions relating to the Act, such terms shall be interpreted and defined consistent with usage and definitions of such terms in the Act and its supporting rules and regulations.

Non-Assignability

The right of any covered individual to receive any Benefits or payments under this Plan shall not be alienable by the covered individual by assignment or any other method and shall not be subject to claims by the covered individual's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to the extent required by law.

Without limiting the foregoing, no Claim for Benefits under the Plan, and no rights related directly or indirectly to any such Claim (including, without limitation, the right to pursue an internal Claim or appeal, the right to pursue litigation for payment of Benefits, the right to pursue litigation for breach of fiduciary duty, the right to pursue litigation to recover any statutory penalties, or the right to assign payment), may be assigned to an Out-of-Network Provider without the Plan Administrator's written consent. In its discretion, the Plan Administrator may voluntarily pay (or cause to be paid) Benefits directly to an Out-of-Network Provider on behalf of a covered individual, and such payment will not constitute an assignment of rights or Benefits and will not be deemed a waiver of this anti-assignment provision as to that covered individual or any other covered individual.

Group Benefit Plan Notice of Privacy Practices

Please carefully review this notice. It describes how medical information about you may be used and disclosed and how you can get access to this information.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) imposes numerous requirements on the use and disclosure of individual health information by CommonSpirit Health plans. This information, known as protected health information, includes almost all individually identifiable health information held by a plan — whether received in writing, in an electronic medium, or as an oral communication. This notice describes the privacy practices of these plans: Medical, Prescription Drug, Dental, Vision, EAP, Flexible Benefits and Wellness plans. The plans covered by this notice may share health information with each other to carry out treatment, payment, or health care operations. These plans are collectively referred to as the Plan in this notice, unless specified otherwise.

The Plan's duties with respect to health information about you

The Plan is required by law to maintain the privacy of your health information and to provide you with this notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. It's important to note that these rules apply to the Plan, not CommonSpirit Health as an employer — that's the way the HIPAA rules work. Different policies may apply to other CommonSpirit programs or to data unrelated to the Plan.

How the Plan may use or disclose your health information

The privacy rules generally allow the use and disclosure of your health information without your permission (known as an authorization) for purposes of health care treatment, payment activities, and health care operations. Here are some examples of what that might entail:

* **Treatment** includes providing, coordinating, or managing health care by one or more healthcare providers or doctors. Treatment can also include coordination or management of care between a provider and a third party, and consultation and referrals between providers. For example, the Plan may share your health information with physicians who are treating you. Further, the Plan may use your health information to contact you to inform you about possible treatment options or alternatives, or to tell you about health-related services available to you. For example, if you are diagnosed or treated for conditions related to high-blood pressure, we may contact you to inform you of available treatment options for that medical condition and where you could access a health care provider to ensure your healthcare is being properly managed.

* **Payment** includes activities by this Plan, other plans, or providers to obtain premiums, make coverage determinations, and provide reimbursement for health care. This can include determining eligibility, reviewing services for Medical Necessity or appropriateness, engaging in utilization management activities, claims management, and billing; as well as performing "behind the scenes" plan functions, such as risk adjustment, collection, or reinsurance. For example, the Plan may share information about your coverage or the expenses you have incurred with another health plan to coordinate payment of benefits.

* **Health care operations** include activities by this Plan (and, in limited circumstances, by other plans or providers), such as wellness and risk assessment programs, quality assessment and improvement activities, customer service, and internal grievance resolution. Note that such programs and activities may be provided by and/or be administered through organizations or entities that are affiliated with CommonSpirit, such as Clinically Integrated Network (CIN), if such organization or entity has entered into an agreement to provide such services to the Plan. Such affiliated organizations and entities may use and disclose your health information received from the Plan; however, they are only permitted to use health information disclosed to it for the purposes of providing the services for which they were retained by the Plan, and as described in this Notice. Health care operations also include evaluating vendors; engaging in credentialing, training, and accreditation activities; performing underwriting or premium rating; arranging for medical review and audit activities; and conducting business planning and development. For example, the Plan may use information about your claims to audit the third parties that approve payment for Plan benefits.

The amount of health information used, disclosed or requested will be limited and, when needed, restricted to the minimum necessary to accomplish the intended purposes, as defined under the HIPAA rules. If the Plan uses or discloses PHI for underwriting purposes, the Plan will not use or disclose PHI that is your genetic information for such purposes.

How the Plan may share your health information

The Plan, or its health insurer or CIN, may disclose your health information without your written authorization to CommonSpirit for plan administration purposes. CommonSpirit may need your health information to administer benefits under the Plan. CommonSpirit agrees not to use or disclose your health information other than as permitted or required by the Plan documents and by law.
CommonSpirit has designated and trained certain employees on the proper management and care of your health information, accordingly, only those employees who have been designated and trained by CommonSpirit will have access to your health information for plan administration functions.

Here's how additional information may be shared between the Plan and CommonSpirit, as allowed under the HIPAA rules:

* The Plan, or its insurer or CIN, may disclose "summary health information" to CommonSpirit, if requested, for purposes of obtaining premium bids to provide coverage under the Plan or for modifying, amending, or terminating the Plan. Summary health information is information that summarizes participants' claims information, from which names and other identifying information have been removed.
* The Plan, or its insurer or CIN, may disclose to CommonSpirit information on whether an individual is participating in the Plan or has enrolled or disenrolled in an insurance option offered by the Plan. In addition, you should know that CommonSpirit cannot and will not use health information obtained from the Plan for any employment-related actions. However, health information collected by CommonSpirit from other sources — for example, under the Family and Medical Leave Act, Americans with Disabilities Act, or workers' compensation programs — is not protected under HIPAA (although this type of information may be protected under other federal or state laws).

State law may further limit the permissible ways the Plans use or disclose your health information. If an applicable state law imposes stricter restrictions on the Plans, we will comply with that state law.

Other allowable uses or disclosures of your health information

In certain cases, your health information can be disclosed without authorization to a family member, close friend, or other person you identify who is involved in your care or payment for your care.
Information about your location, general condition, or death may be provided to a similar person (or to a public or private entity authorized to assist in disaster relief efforts). You'll generally be given the chance to agree or object to these disclosures (although exceptions may be made — for example, if you're not present or if you're incapacitated). In addition, your health information may be disclosed without authorization to your legal representative.

The Plan also is allowed to use or disclose your health information without your written authorization for the following activities:

Workers' compensation	Disclosures to workers' compensation or similar legal programs that provide benefits for work-related injuries or illness without regard to fault, as authorized by and necessary to comply with the laws
Necessary to prevent serious threat to health or safety	Disclosures made in the good-faith belief that releasing your health information is necessary to prevent or lessen a serious and imminent threat to public or personal health or safety, if made to someone reasonably able to prevent or lessen the threat (or to the target of the threat); includes disclosures to help law enforcement officials identify or apprehend an individual who has admitted participation in a violent crime that the Plan reasonably believes may have caused serious physical harm to a victim, or where it appears the individual has escaped from prison or from lawful custody
Public health activities	Disclosures authorized by law to persons who may be at risk of contracting or spreading a disease or condition; disclosures to public health authorities to prevent or control disease or report child abuse or neglect; and disclosures to the Food and Drug Administration to collect or report adverse events or product defects
Victims of abuse, neglect, or domestic violence	Disclosures to government authorities, including social services or protected services agencies authorized by law to receive reports of abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk)
Judicial and administrative proceedings	Disclosures in response to a court or administrative order, subpoena, discovery request, or other lawful process (the Plan may be required to notify you of the request or receive satisfactory assurance from the party seeking your health information that efforts were made to notify you or to obtain a qualified protective order concerning the information)
Law enforcement purposes	Disclosures to law enforcement officials required by law or legal process, or to identify a suspect, fugitive, witness, or missing person; disclosures about a crime victim if you agree or if disclosure is necessary for immediate law enforcement activity; disclosures about a death that may have resulted from criminal conduct; and disclosures to provide evidence of criminal conduct on the Plan's premises
Decedents	Disclosures to a coroner or medical examiner to identify the deceased or determine cause of death; and to funeral directors to carry out their duties
Organ, eye, or tissue donation	Disclosures to organ procurement organizations or other entities to facilitate organ, eye, or tissue donation and transplantation after death
Research purposes	Disclosures subject to approval by institutional or private privacy review boards, subject to certain assurances and representations by researchers about the necessity of using your health information and the treatment of the information during a research project
Health oversight activities	Disclosures to health agencies for activities authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs or civil rights laws
Specialized government functions	Disclosures about individuals who are Armed Forces personnel or foreign military personnel under appropriate military command; disclosures to authorized federal officials for national security or intelligence activities; and disclosures to correctional facilities or custodial law enforcement officials about inmates
HHS investigations	Disclosures of your health information to the Department of Health and Human Services to investigate or determine the Plan's compliance with the HIPAA privacy rule
Business Associates	Disclosures to the Plan's third-party business associates (e.g., a health insurance broker/consultant, wellness coordinator, claims billing organization, etc.) that perform activities or services on behalf of the Plan. Each business associate must agree in writing to protect the confidentiality of your medical information

Except as described in this notice, other uses and disclosures will be made only with your written authorization. For example, in most cases, the Plan will obtain your authorization before it communicates with you about products or

programs if the Plan is being paid to make those communications. Certain types of medical information have additional protection under state orfederal law. For instance, information about communicable disease and HIV/AIDS, drug and alcohol abuse treatment, genetic testing, and evaluation and treatment for a serious mental illness is treated differently than other types of medical information. For those types of information, we are required to get your permission before disclosing it to others in many circumstances. The Plan will never sell your health information unless you have authorized us to do so. You may revoke your authorization as allowed under the HIPAA rules. However, you can't revoke your authorization with respect to disclosures the Plan has already made. You will be notified of any unauthorized access, use, or disclosure of your unsecured health information as required by law.

Your individual rights

You have the following rights with respect to your health information the Plan maintains. These rights are subject to certain limitations, as discussed below. This section of the notice describes how you may exercise each individual right. See the table at the end of this notice for information on how to submit requests.

Right to request restrictions on certain uses and disclosures of your health information and the Plan's right to refuse

You have the right to ask the Plan to restrict the use and disclosure of your health information for treatment, payment, or health care operations, except for uses or disclosures required by law.

You have the right to ask the Plan to restrict the use and disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. You also have the right to ask the Plan to restrict use and disclosure of health information to notify those persons of your location, general condition, or death — or to coordinate those efforts with entities assisting in disaster relief efforts. If you want to exercise this right, your request to the Plan must be in writing.

The Plan is not required to agree to a requested restriction. If the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan (including an oral agreement), or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. The Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction.

An entity covered by these HIPAA rules (such as your health care provider) or its business associate must comply with your request that health information regarding a specific health care item or service not be disclosed to the Plan for purposes of payment or health care operations if you have paid out of pocket and in full for the item or service.

Right to receive confidential communications of your health information

If you think that disclosure of your health information by the usual means could endanger you in some way, the Plan will accommodate reasonable requests to receive communications of health information from the Plan by alternative means or at alternative locations.

If you want to exercise this right, your request to the Plan must be in writing and you must include a statement that disclosure of all or part of the information could endanger you.

Right to inspect and copy your health information

With certain exceptions, you have the right to inspect or obtain a copy of your health information in a "designated record set." This may include medical and billing records maintained for a health care provider; enrollment, payment, claims adjudication, and case or medical management record systems maintained by a plan; or a group of records the Plan uses to make decisions about individuals.

However, you do not have a right to inspect or obtain copies of psychotherapy notes or information compiled for civil, criminal, or administrative proceedings. The Plan may deny your right to access, although in certain circumstances, you may request a review of the denial.

If you want to exercise this right, your request to the Plan must be in writing. Within 30 days of receipt of your request, the Plan will provide you with one of these responses:

- The access or copies you requested.
- A written denial that explains why your request was denied and any rights you may have to have the denial reviewed or file a complaint.
- A written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

You may also request your health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. The Plan may provide you with a summary or explanation of the information instead of access to or copies of your health information, if you agree in advance and pay any applicable fees. The Plan also may charge reasonable fees for copies or postage. If the Plan doesn't maintain the health information but knows where it is maintained, you will be informed where to direct your request.

If the Plan keeps your records in an electronic format, you may request an electronic copy of your health information in a form and format readily producible by the Plan. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous, and specific. Any charge that is assessed to you for these copies must be reasonable and based on the Plan's cost.

Right to amend your health information that is inaccurate or incomplete

With certain exceptions, you have a right to request that the Plan amend your health information in a designated record set. The Plan may deny your request for a number of reasons. For example, your request may be denied if the health information is accurate and complete, was not created by the Plan (unless the person or entity that created the information is no longer available), is not part of the designated record set, or is not available for inspection (e.g., psychotherapy notes or information compiled for civil, criminal, or administrative proceedings).

If you want to exercise this right, your request to the Plan must be in writing, and you must include a statement to support the requested amendment. Within 60 days of receipt of your request, the Plan will take one of these actions:

- Make the amendment as requested.
- Provide a written denial that explains why your request was denied and any rights you may have to disagree or file a complaint.
- Provide a written statement that the time period for reviewing your request will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request.

Right to receive an accounting of disclosures of your health information

You have the right to a list of certain disclosures of your health information the Plan has made. This is often referred to as an "accounting of disclosures." You generally may receive this accounting if the disclosure is required by law, in connection with public health activities, or in similar situations listed in the table earlier in this notice, unless otherwise indicated below. You may receive information on disclosures of your health information for up to six years before the date of your request. You do not have a right to receive an accounting of any disclosures made in any of these circumstances:

- For treatment, payment, or health care operations to you about your own health information
- Incidental to other permitted or required disclosures
- Where authorization was provided
- To family members or friends involved in your care (where disclosure is permitted without authorization)
- For national security or intelligence purposes or to correctional institutions or lawenforcement officials in certain circumstances
- As part of a "limited data set" (health information that excludes certain identifying information)

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request to the Plan must be in writing. Within 60 days of the request, the Plan will provide you with the list of disclosures or a written statement that the time period for providing this list will be extended for no more than 30 more days, along with the reasons for the delay and the date by which the Plan expects to address your request. You may make one request in any 12-month period at no cost to you, but the Plan may charge a fee for subsequent requests. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

Right to obtain a paper copy of this notice from the Plan upon request

You have the right to obtain a paper copy of this privacy notice upon request. Even individuals who agreed to receive this notice electronically may request a paper copy at any time. CommonSpirit Health Notice of Health Information Privacy Practices is available to you upon your request and may be obtained by writing to:

CommonSpirit Health Benefits Contact Center
Dept: CSH
PO Box 981901
El Paso, TX 79998

You also may obtain a copy of this notice through your local HR or online by visiting http://chibenefitplans.net.

Right to receive Notice of a breach

You have the right to be notified in writing following a breach of your health information that is not secured in accordance with certain security standards.

Changes to the information in this notice

The Plan must abide by the terms of the privacy notice currently in effect. However, the Plan reserves the right to change the terms of its privacy policies, as described in this notice, at any time and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If changes are made to the Plan's privacy policies described in this notice, you will be provided with a revised privacy notice either through mail to your home address on file or online through EmployeeCentral > MyBenefits > Benefit Resources > Plan Information >Required Notices and Additional Resources Notice of Privacy Practices (NPP).

Complaints

If you believe your privacy rights have been violated or your Plan has not followed its legal obligations under HIPAA, you may complain to the Plan and to the Secretary of the U.S. Department of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, please visit the following website to file a complaint online or to obtain a Health Information Privacy

Complaint form that can be printed and mailed to the regional Office for Civil Rights, Department of Health & Human Services.

www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

Contact

For more information on the Plan's privacy policies or your rights under HIPAA, contact:

VP National Privacy Officer/Corporate Responsibility
CommonSpirit Health
lori.lamb@commonspirit.org

Additional contacts
The following is a list of key persons or offices you may need to contact to exercise your rights under the HIPAA privacy rule for different benefit plans offered by CommonSpirit Health:

	Restricted disclosures	Confidential communications	Access to copies of your health information
Medical Plan – Blue Cross Blue Shield of Illinois	Director, Privacy Office Blue Cross Blue Shield of Illinois P.O. Box 804836 Chicago, IL 60680-4110 Phone: 877.361.7594 (or see back of ID card) Website: http://www.bcbsil.com/important_info/hipaa.html		
Prescription Drug Plan – Capital Rx	Privacy Officer Capital Rx, LLC Attn: Chief Privacy Officer 228 Park Avenue S., Suite 87234 New York, NY 10003 Email: Privacy@cap-rx.com		
Dental Plan – Delta Dental Colorado	Privacy Officer Delta Dental of Colorado Ed Williams | CIA, CRMA Director – Audit, Risk and Compliance Services HIPAA@ddpco.com Delta Dental of Colorado 6465 Greenwood Plaza Blvd., Ste. 900 | Centennial, CO 80111		
Dental Plan – Cigna	Privacy Officer Cigna Nondiscrimination Complaint Coordinator P.O. Box 188016 Chattanooga, TN 37422 Email: ACAGrievance@cigna.com org		
Vision Plan – VSP	VSP, Attention: Privacy Specialist 3333 Quality Drive MS-163 Rancho Cordova CA 95670 Phone: (916) 858.7432 Email: HIPAA@vsp.com		

Plan Sponsor

CommonSpirit Health
3900 Olympic Boulevard, Suite 300
Erlanger, KY 41018-1099

Plan Name

CommonSpirit Health Medical Plan (a component program of the CommonSpirit Health ERISA Welfare Benefit Plan)

Employer Identification Number

47-0617373

Plan Administrator

CommonSpirit Health
3900 Olympic Boulevard, Suite 300
Erlanger, KY 41018-1099

Plan Administrator's Authority

The Plan Administrator shall control and manage the operation and administration of the Plan. The Plan Administrator shall have the exclusive right and power to interpret the Plan, make factual determinations, and to decide all matters arising under the Plan, including eligibility for Benefits and the right to remedy possible ambiguities, inconsistencies, or omissions. All determinations of the Plan Administrator with respect to any matter relating to the administration of the Plan shall be conclusive and binding on all persons.

The Plan Administrator shall have the following additional powers and duties:

- To require any person to furnish such reasonable information as it may request for the proper administration of the Plan as a condition to receiving any Benefits under the Plan;
- To make and enforce such rules and regulations and prescribe the use of such forms as it shall deem necessary for the efficient administration of the Plan;
- To decide on questions concerning the Plan and the eligibility of any Employee to participate in the Plan, in accordance with the provisions of the Plan;
- To determine the amount of Benefits which shall be payable to any person in accordance with the provisions of the Plan, and to provide a full and fair review to any Participant whose Claim for Benefits has been denied in whole or in part;
- To designate other persons to carry out any duty or power which would otherwise be a responsibility of the Plan Administrator under the terms of the Plan; and
- To interpret Plan terms and provisions.

Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons as it may deem necessary or desirable in connection with the administration of Claims or other operations of the Plan. The Plan Administrator and any person to whom any duty or power in connection with the operation of the Plan is delegated may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including Employees who are actuaries or accountants), consultant (internal medical director, ombudsman with clinical background, etc.), third party administration service Provider, legal counsel, or other Specialist.

Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service Provider, actuary, consultant, accountant, Specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, shall be paid by the Employer.

Funding Policy
The Employer shall fund this Plan out of its general assets. However, the Employer shall also have the right to, in the future, enter into a contract with one or more insurance companies for the purposes of providing any Benefits under the Plan and to replace any of such insurance companies or contracts.
Any dividends, retroactive rate adjustments or other refunds of any type which may become payable under any such insurance contract, to the extent allocable to contributions made by the Employer, shall not be assets of the Plan but shall be the property of and shall be retained by the Employer.

Type of Plan
Welfare Benefit Plan

Plan Number
513

Type of Plan Administration
Employer Administered

Claim Administration
Claims for medical benefits should be directed to:

Blue Cross Blue Shield of Illinois
300 East Randolph
Chicago, IL 60601

Agent for Service of Legal Process
General Counsel for CommonSpirit Health

1999 Broadway
Suite 2605
Denver, CO 80202

Service for legal process may also be made on the Plan Administrator

Eligibility
Varies by Market-Based Organization or facility, see the Eligibility Addendum

Minimum Maternity Benefits
Group health plans and health insurance issuers offering group insurance coverage, generally may not, under Federal law restrict Benefits for any Hospital length of stay in connection with childbirth for the mother or newborn Child to less than 48 hours following a normal vaginal delivery, or less than 96 hours following a cesarean section, or require that a Provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay in excess of the above periods. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Loss of Benefits
The provisions regarding termination of coverage and limitations and exclusions of Benefits that may result in reduction or loss of Benefits are explained in this Summary Plan Description.

Contributions
Varies by Market-Based Organization or facility and can be found in your open enrollment materials

Funding Arrangements
The cost of coverage for employees and their families is paid in part by Employer out of its general assets, and in part by employee paid premiums. The employee portion of the cost of coverage may be paid pre-tax through the Employer sponsored cafeteria plan. Benefits under the plan are paid directly out of the general assets of Employer. There is no special fund, trust, or insurance policy from which benefits are paid.

Plan Year
The twelve-month period from January 1 to December 31. (See definition of Benefit Plan Year.)

Future of the Plan

Although CommonSpirit Health intends to continue the Plan indefinitely, CommonSpirit Health reserves the right to amend or end the Plan at any time for any reason. Changes may be made retroactively, if necessary, to qualify or maintain the Benefits under the Internal Revenue Code or the Employee Retirement Income Security Act of 1974 (ERISA). If the plan is amended or ends, you and other active members may not receive Benefits as described in this booklet. However, you may be entitled to receive different Benefits, or Benefits under different conditions. In no event will you become entitled to any vested rights under this Plan.

Glossary of Terms

The definitions in this section are terms that are written in capital letters and are used in various sections throughout this Summary Plan Description and have a specific meaning when applied to your health care coverage. When you come across these terms while reading this SPD, please refer to these definitions because they will help you understand some of the limitations or special conditions that may apply to your Benefits. If a term within a definition begins with a capital letter, it means that the term is also defined in these definitions. All definitions have been arranged in alphabetical order. A term that appears in only one section may be defined within that section rather than within this Glossary of Terms.

Accident or Accidental Injury…means an accidental bodily injury that is not related to any Illness.

Acupuncture…means the technique of passing long, thin needles through the skin to specific points on the body for treatment of certain Conditions.

Acupuncturist…means a duly licensed acupuncturist.

Admission…means formal acceptance as a patient to a Hospital or other covered facility for a health Condition.

Affordable Care Act (ACA) Preventive Care Drugs…means certain preventive care drugs, as defined by the United States Preventive Services Task Force which are covered 100 percent by the Medical Plan, when prescribed by a physician:

- Aspirin – limited to persons age 45 through 79 years
- Bowel Preparation for Colonoscopy Screening – limited to persons age 45 to 75 years
- Fluoride – limited to persons through the age of 5 years
- Folic Acid – limited to females through the age of 55 years
- Iron – limited to persons less than 1 year of age
- Vitamin D – limited to persons 65 or older

Ambulance…means any licensed land, air, or water vehicle designated, constructed, or equipped for and used for transporting persons in need of medical or surgical attention.

Ambulance Transportation…means local transportation in a specially-equipped certified vehicle from your home, scene of Accident or medical Emergency to a Hospital, between Hospital and Hospital, between Hospital and Skilled Nursing Facility, or from a Skilled Nursing Facility or Hospital to your home. If there are no facilities in the local area equipped to provide the care needed, Ambulance Transportation then means the transportation to the closest facility that can provide the necessary services.

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

Anesthesia Services…means the administration of anesthesia and the performance of related procedures by a Physician or a Certified Registered Nurse Anesthetist which may be legally rendered by them respectively.

Annual Benefit Enrollment…means the period specified by CommonSpirit Health during which you may elect or change coverage for you and your eligible Dependents.

Applied Behavior Analysis Therapy…means therapy used to improve or change specific behaviors. Applied Behavior Analysis therapy focuses on the principles that explain how learning takes place.

Positive reinforcement is one such principle. When a behavior is followed by some sort of reward, the behavior is more likely to be repeated. Applied behavior analysis is the use of techniques and principles to bring about meaningful and positive change in behavior.

Benefit Year…means the period in which your Deductibles, Coinsurance maximums and other Benefit maximums accrue. When you first enroll in the Medical Plan, your first Benefit Year begins on your Coverage Date and ends on December 31 of that year. On subsequent years, your Benefit Year will be the 12-month period from January 1 to December 31.

Benefits…mean Medically Necessary Covered Services or Supplies that qualify for payment under this Plan.

Billed Amount…means the amount that a Provider bills for a service or supply, or the retail price that a Pharmacy charges for a Prescription Drug, whether or not it is covered under this Plan.

Birth Center…means a duly licensed facility, institution or place where births are planned to occur following a normal, uncomplicated, low-risk pregnancy.

Brand Name Drug…means a drug item which is under the patent by its original innovator or marketer. The patent protects the drug from competition from other drug companies.

Breach…means the unauthorized acquisition, access, use, or disclosure of Unsecured PHI which compromises the security or privacy of such information. For purposes of this definition, "compromises the security or privacy of such information" means poses a significant risk of financial, reputational, or other harm to the individual who is the subject of the PHI. A use or disclosure of a Limited Data Set, that also excludes date of birth and zip code, does not compromise the security and privacy of PHI. Breach excludes:

- Any unintentional acquisition, access, or use of PHI by a Workforce Member or person acting under the authority of a Covered Entity or a Business Associate, if such acquisition, access, or use was made in good faith and within the scope of authority and does not result in further use or disclosure in a manner not permitted by HIPAA.
- Any inadvertent disclosure by a person who is authorized to access PHI at a Covered Entityor Business Associate to another person authorized to access PHI at the same Covered Entity or Business Associate, or Organized Health Care Arrangement in which the Covered Entity participates, and the information received as a result of such disclosure is not further used or disclosed in a manner not permitted under HIPAA.
- A disclosure of PHI where a Covered Entity or Business Associate has a good faith belief that an unauthorized person to whom the disclosure was made would not reasonably have been able to retain such information.

Business Associate…means any third-party, other than the Plan Sponsor or Plan Sponsor personnel, who receives, uses, or discloses Protected Health Information in connection with the performance of an administrative function on behalf of the Plan or the Organized Health care Arrangement, or in connection with the provision of legal, actuarial, accounting, consulting, data aggregation, management, administrative, accreditation or financial services to or on behalf of the Plan or the Organized Health Care Arrangement, within the meaning of the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996, 21 CFR Parts 160 and 164 ("HHS Reg."),
§160.103.

CommonSpirit Facility…means a Hospital or other health care facility which is fully or partially owned by CommonSpirit Health.

Certificate of Credible Coverage…means a certificate disclosing information relating to your Credible Coverage under a health care Benefit program for purposes of reducing any Preexisting Condition exclusion imposed by any group health plan coverage.

Certified Clinical Nurse Specialist…means a duly licensed certified clinical nurse Specialist.

Certified Nurse-Midwife…means a duly licensed certified nurse-midwife.

Certified Nurse Practitioner…means a duly licensed certified nurse practitioner.

Certified Registered Nurse Anesthetist or CRNA…means a duly licensed certified nurse anesthetist.

Chemical Dependency…means Substance Use Disorder or dependence on drugs and/or alcohol, including abuse of Prescription Drugs.

Chemotherapy…means the treatment of malignant Conditions by pharmaceutical and/or biological anti-neoplastic drugs.

Child…means:

- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, of an Eligible Person by birth, marriage, legal adoption, or placement for adoption who is under the age of 26 for whom the eligible Person is required by law to provide health coverage; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 of an eligible Legally Domiciled Adult; or
- A dependent (within the meaning of Code § 105(b)) child, married or unmarried, under the age of 26 who resides primarily in the Eligible Person's household and for whom the Eligible Person is the Legal Guardian, such as a court approved foster child; or
- A dependent (within the meaning of Code § 105(b)) unmarried child of the Eligible Person by birth, marriage, legal adoption, or placement for adoption who is age 26 or over, who is dependent upon the Eligible Person for support and maintenance because of a continuous developmental or physical disability that began prior to the date the dependent attained age 26 and:
    - The disabled dependent was covered by this Plan or other group medical insurance coverage as a disabled dependent prior to reaching age 26.
    - If enrolling for the first time, the disabled dependent who is 26 years of age or older of a newly Eligible Person may be enrolled for coverage if the Eligible Person enrolls during the initial eligibility period and provides proof that the dependent satisfies the foregoing requirements within 31 days of the initial date of eligibility.

The Plan may request documentation of the dependent's continued disability on an annual basis. Once appropriate documentation is received, the disabled Dependent shall be eligible for coverage so long as the Dependent continues to be disabled, unless coverage otherwise terminates under the Plan. The disabled dependent must be continuously covered under the Plan in order to maintain eligibility.

Chiropractor…means a duly licensed chiropractor.

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

Claims Administrator…means Blue Cross Blue Shield of Illinois for medical claims and Capital Rx for Prescription Drug claims.

Claim Payment…means the Benefit payment calculated by the Claims Administrator, after submission of a Claim, in accordance with the Benefits described in this SPD. All Claim Payments will be calculated on the basis of the Eligible Charge for Covered Services rendered to you, regardless of any separate financial arrangement between the Claims Administrator and a particular Provider.

Clinical Laboratory…means a duly licensed clinical laboratory.

Clinical Professional Counselor…means a duly licensed clinical professional counselor.

Clinical Social Worker…means a duly licensed clinical social worker.

Clinically Integrated Network (CIN)… means a network of providers, facilities and ancillary services collaborating to improve the health of their patients.

COBRA…means those sections of the Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272), as amended, which regulate the conditions and manner under which an Employer can offer continuation of group health insurance to Eligible Persons whose coverage would otherwise terminate under the terms of this program.

Coinsurance…means that you and the Plan share a percentage the Eligible Charge.

Condition…means any disease, Illness, Accident or Accidental Injury, bodily dysfunction, pregnancy, Substance Use Disorder, or Illness Affecting Mental Health.

Copayment or Copay…means a specified dollar amount that you are required to pay towards a Covered Service.

Coverage Date…means the date on which your coverage under the Medical Plan begins.

Covered Entity…means a health plan, health care clearinghouse, or a health care Provider who transmits Protected Health Information in electronic form.

Covered Provider…means a Provider covered under this Plan.

Covered Service or Covered Services and Supplies…means a service and/or supply specified in this SPD for which Benefits will be provided.

Credible Coverage…means coverage you had under any of the following:

- A group health plan;
- Health insurance coverage for medical care under any Hospital or medical service policyplan, Hospital, or medical service plan contract, or HMO contract offered by a health insurance insurer;
- Medicare (Parts A or B of Title XVIII of the Social Security Act);
- Medicaid (Title XIX of the Social Security Act);
- Medical care for members and certain former members of the uniformed services andtheir Dependents;
- A medical care program of the Indian Health Service or of a tribal organization;
- A state health Benefits risk pool;
- A health plan offered under the Federal Employees' Health Benefits Program;
- A public health plan established or maintained by a State or any political subdivision of a State, the U.S. government, or a foreign country;
- A health plan under Section 5(e) of the Peace Corps Act; or
- State Children's Health Insurance Program (Title XXI of the Social Security Act).

Custodial Care Service…means any services primarily for personal comfort or convenience that provides general maintenance, preventive, and/or protective care without any clinical likelihood of improvement of your Condition. Custodial Care Services also means those services that do not require the technical skills, professional training, and clinical assessment ability of medical and/or nursing personnel in order to be safely and effectively performed. These services can be safely provided by trained or capable non-professional personnel, are to assist with routine medical needs (e.g., simple care and dressing, administration of routine medications, etc.) and are to assist with activities of daily living (e.g., bathing, eating, dressing, etc.). Custodial Care Services also means providing care on a continuous Inpatient or Outpatient basis without any clinical improvements by you.

Deductible… means the amount you have to pay before your Medical Plan Benefits subject to Coinsurance begin. Standard Health Plan exceptions to the deductible are preventive care services, office visits, coinsurance amounts, CommonSpirit Facility charges and Prescription Drugs. Standard HDHP Plan exceptions to the deductible are preventive care services.

Dentist…means a duly licensed Dentist.

Dependent…means your Spouse, an eligible Legally Domiciled Adult and/or Child(ren) as defined in this section of the Summary Plan Description. Only one non-child Dependent can be enrolled.

Diabetes Educator…means a duly licensed person who is legally certified to supervise diabetes Outpatient self-management training and educational services. These services are designed to teach diabetics self-management skills and lifestyle changes to effectively manage diabetes and to avoid complications from diabetes.

Diagnostic Service…means tests rendered for the diagnosis of your symptoms and which are directed toward evaluation or progress of a Condition, disease or Accidental Injury. Such tests include, but are not limited to, x-rays, pathological services, Clinical Laboratory tests, pulmonary function studies, electrocardiograms, electroencephalograms, radioisotope tests and electromyograms.

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

Dietician…means a duly licensed dietitian.

Drug Utilization Review (DUR)…means a system-based drug Claims review process which alerts Pharmacists and Physicians to important therapeutic issues regarding the use of medication. By alerting Physicians and Pharmacists to issues, DUR reduces risk and improves the quality of care for the patient and reduces unwarranted costs.
Durable Medical Equipment Provider…means a duly licensed durable medical equipment Provider.

Effective Date…means the first day of coverage under CommonSpirit Health's health plan or the first day following the waiting period.

Eligible Charge…means (a) in the case of a Provider other than a Professional Provider which has a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, such Provider's Billed Amount for Covered Services and (b) in the case of a Provider other than a Professional Provider which does not have a written agreement with the Claims Administrator to provide care to you at the time Covered Services are rendered, the amount for Covered Services as determined by the Claims Administrator based on the following order:

- The charge which is within the range of charges other similar Hospitals or facilities in similar geographic areas charge their patients for the same or similar services, as reasonably determined by the Claims Administrator, if available,
- The amount that the Center for Medicare & Medicaid Services (CMS) reimburses the Hospitals or facilities in similar geographic areas for the same or similar services rendered to members in the Medicare program, or
- The charge which the particular Hospital or facility usually charges its patients for Covered Services.

Eligible Person…means an Employee of the Employer who meets the eligibility requirements for this coverage, as described in the Eligibility section and the Eligibility Addendum.

Embedded... means the individual Deductible and Out-of-Pocket Maximums are included in the family Deductible and Out-of-Pocket Maximums. Family members will accumulate deductible and Out-of-Pocket Maximum amounts until they meet the individual limits listed. The remaining family members will accumulate amounts to meet the family limits. No individual of a family will ever meet the entire family limits.

Emergency or Medically Urgent Situation…means an accidental traumatic bodily injury or other medical Condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that the absence of immediate medical attention could reasonably be expected by a Prudent Layperson who possesses an average knowledge of health and medicine to:

- Place a patient's health in serious jeopardy, or with respect to a pregnant woman, placethe health of the woman or her unborn Child in serious jeopardy;
- Result in serious impairment to the patient's bodily functions;
- Result in serious dysfunction of a bodily organ or body part; or,

In the opinion of a Physician with knowledge of the patient's medical Condition, would subject the patient to sever pain that cannot be managed without the services in question. With respect to a pregnant woman who is having contractions, an Emergency exists where there is inadequate time to affect a safe transfer to another Hospital before delivery, or the transfer may pose a threat to the health or safety of the woman or unborn Child.
Conditions that require immediate Emergency treatment include, but are not limited to the following:

- Heart attacks;
- Strokes;
- Convulsions;
- Serious burns;
- Bone fractures;
- Wounds requiring sutures (stitches);
- Poisoning;
- Severe chest or abdominal pains;
- Loss of consciousness;
- Major depression with significant suicidal intent;
- Psychosis with associated homicidal intent; and
- Manic episode resulting in inability to care for oneself.

In addition, the service provided must be a Covered Service or Supply, and not one that is normally treated on a non-Emergency basis.

Emergency Accident Care…means the initial Outpatient treatment of accidental injuries which a Prudent Layperson would consider an Emergency including related Diagnostic Services.

Emergency Medical Care…means services provided for the initial Outpatient treatment, including related Diagnostic Services, for a medical Condition, which a Prudent Layperson would consider an Emergency and would reasonably require you to seek immediate medical aid. Examples of Emergency Medical Conditions are: severe chest pains, convulsions, or persistent severe abdominal pains.

Employee…means an individual employed by the Employer who meets the following requirements:

- Employer withholds income tax on any portion of his or her income and Social Security contributions are made for him or her by the Employer, and
- Such individual is determined by the Employer to be an Employee, for purposes of the Employer's payroll records.
- "Employee" does not include a "Leased Employee," as defined in Code Section 414(n)(2). Only individuals who are paid as Employees from the Employer's payroll and are treated by the Employer as Employees will be considered Employees for purposes of the Plan.
- Any individual who is treated as an independent contractor by the Employer is not an Employee. Also, an individual who renders services to the Employer pursuant to an agreement between the Employer and a leasing organization, temporary employment agency or any other organization is not an Employee.
- Any individual who is retroactively or in any other way held or found to be a "statutory" or "common-law" Employee of the Employer will not be eligible to participate in the Plan for any period he or she was not contemporaneously treated as an Employee by the Employer and considered by the Employer to be an Employee. In addition, such an individual will remain ineligible for participation in the Plan unless the Plan is amended to specifically render the individual eligible for Plan participation.

Employer… means CommonSpirit Health and any facilities/entities listed in the Eligibility Addendum.

Employment Status…means any of the following events that affect the eligibility of you, your Spouse or your Dependent:

- Termination or commencement of employment with CommonSpirit Health;
- Strike or lockout;
- Commencement of or return from an unpaid leave of absence; and
- Change in worksite.

ERISA…means the Employee Retirement Income Security Act of 1974. ERISA applies to health and welfare plans, as well as retirement plans.

Facility Charge…means charges billed for by a CommonSpirit Facility on a universal billing "UB" form. The Facility Charge does not include any charges billed for separately by a Physician or other Provider.

Family Coverage…means coverage for you and your enrolled Dependents under this Plan. For purposes of this SPD Family Coverage will mean Employee/Child(ren), Employee/Spouse or Legally Domiciled Adult, or Employee/Spouse or Legally Domiciled Adult/Child(ren) coverage.

Financial Responsibility…means the degree of financial support sufficient to Claim and eligible Dependent as an exemption of the Eligible Person's federal income tax return.

Formulary…means a listing of preferred Brand-Named Drugs as determined by a committee or Pharmacists and Physicians based on safety, clinical efficacy, and cost of therapy.

Generic Drug…means drug products manufactured and distributed after the patent of the innovator brand-name drug has expired. The Generic Drug must have the same active ingredient, strength, and dosage form as its brand-name counterpart.

Group Coverage…means a plan whose members share a common relationship, such as employment or membership.

HDHP Covered Preventive Drugs...means certain approved drugs that will not be subject to the deductible on the Standard HDHP. The drugs will, however, still have the appropriate coinsurance for the tier of the specific drug. These drugs can be found on the Capital Rx HDHP Plan Preventive Drug List. You can also check the Formulary Drug List for other medications that are covered on the plan. The cost of these drugs will apply to your deductible, and then coinsurance applies. See Pharmacy Coverage of Benefits for additional information.

Health Savings Account (HSA)…means an account funded by you that can be used to cover the cost of covered services, including prescription drugs, up to the IRS annual limit or the accrued amount in your account. You must work with an independent bank to fund the account.

HIPAA…means the Health Insurance Portability and accountability Act of 1996.

Home Health Care Program…means an organized skilled patient care program in which care is provided in the home. Such home care may be rendered by a Hospital's duly licensed home health department or by other duly licensed home health agencies. You must be homebound (that is, unable to leave home without assistance and requiring supportive devices or special transportation) and you must require Skilled Nursing Service on an intermittent basis under the direction of your Physician. This program includes, among other things, Skilled Nursing Service by or under the direction of a registered professional nurse, the services of Physical Therapists, Hospital laboratories, and necessary medical supplies. It does not include Custodial Care Service.

Home Infusion Therapy Provider…means a duly licensed home infusion therapy Provider.

Hospice…means a duly licensed autonomous, centrally administered, nurse-coordinated program providing home, Outpatient, and Inpatient care for a covered Participant who is Terminally Ill and members of the Participant's family. At a Hospice, a team of healthcare Providers assists in providing Palliative Care and support to meet the special needs arising during the final stages of Illness, and during dying and bereavement. This team of Providers includes a doctor and nurse, and may also include a social worker, a clergy member or counselor and volunteers.

Hospice Care Program Provider…means an organization duly licensed to provide Hospice Care Program Services.

Hospice Care Program Service…means a centrally administered program designed to provide for the physical, psychological, and spiritual care for dying persons and their families. The goal of Hospice care is to allow the dying process to proceed with a minimum of patient discomfort while maintaining dignity and a quality of life. Hospice Care Program Service is available in the home, Skilled Nursing Facility, or special Hospice care unit.

Hospital…means a duly licensed institution for the care of the sick which provides services under the care of a Physician including the regular provision of bedside nursing by Registered Nurses. It does not mean health resorts, rest homes, nursing homes, skilled nursing facilities, convalescent homes, and custodial homes of the aged, or similar institutions.

The term Hospital does not include a specialty institution or residential facility, or a U.S. Government Hospital or any other Hospital operated by a governmental unit, unless a charge is made by the Hospital that the patient is legally required to pay without regard to insurance coverage.

Infertility…means the inability to conceive a Child after one year of unprotected sexual intercourse or the inability to sustain a successful pregnancy.

Illness…means physical sickness or disease, pregnancy, or congenital anomaly.

Illness Affecting Mental Health…means those Illnesses, classified as disorders in the current Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association.

Independent Clinical Laboratory…means a duly licensed facility where human materials or specimens are examined for the purpose of diagnosis, prevention, or treatment of a Condition.

Individual Coverage…means coverage under the health care plan for yourself.

Injury…means a bodily injury that is not related to any Illness.

In-Network Provider…means a Professional Provider which has a written agreement with the Claims Administrator to provide services to Participants

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

Intensive Care Unit…means a specialized area in a Hospital where an acutely ill patient receives intensive care or treatment. Included in the Hospital's charge for an Intensive Care Unit are the services of specially trained professional staff and nurses, supplies, and the use of any and all equipment and the patient's board. A coronary care unit is also considered an Intensive Care Unit.

Investigational…means procedures, drugs, devices, services and/or supplies which

- Are provided or performed in special settings for research purposes or under a controlled environment and which are being studied for safety, efficiency, effectiveness, and/or
- Are awaiting endorsement by the appropriate National Medical Specialty College or federal government agency for general use by the medical community at the time they are rendered to you, and
- Specifically, with regard to drugs, combination of drugs and/or devices, are not finally approved by the Food and Drug Administration at the time used or administered to you.

Law Enforcement Official…means an officer or employee of any agency or authority of the United States, a state, a territory, a political subdivision of a state or territory, or an Indian tribe, who is empowered by law to:
Investigate or conduct an official inquiry into a potential violation of law; or Prosecute or otherwise conduct a criminal, civil, or administrative proceeding arising from an alleged violation of law.

Legal Guardian or Guardianship…means an individual who was appointed as guardian, conservator, loco parentis or similar role for a Child by a court having appropriate jurisdiction over such Child.

Legally Domiciled Adult means an individual over 18 who has, for at least six months, lived in the same principal residence of an Employee and remains a member of that Employee's household throughout the coverage period; and who either:

- Has an on-going, exclusive and committed relationship with the Employee (not a casual roommate or tenant), shares basic living expenses and is financially interdependent with the Employee, is neither legally married to anyone else nor legally related to the Employee by blood in any way that would prohibit marriage.
- Is the Employee's blood adult relative who meets the definition of his or her tax dependent as defined by Section 152 of the Internal Revenue Code during the coverage period and is not considered a Child as defined in this section of the Summary Plan Description.

Legend Drug…means a drug that is approved by the U.S. Food and Drug Administration (FDA) and is required by federal or state law to be dispensed to the public only on prescription of a licensed physician or other licensed provider. Legend drugs are also called prescription drugs.

Level of Coverage…means the medical Plan option selected by the Plan Participant.

Lifetime Maximum…means the maximum amount that this Plan will pay over the course of an Employee or Dependent's lifetime.

Maintenance Occupational, Physical and/or Speech Therapy…means therapy administered to you to maintain a level of function at which no demonstrable and measurable improvement of a Condition will occur.

Marriage and Family Therapist…means a duly licensed marriage and family therapist.

Maternity Service…means the services rendered for normal pregnancy. A normal pregnancy means an intrauterine pregnancy which, through vaginal delivery, results in an infant, who is not premature or preterm. Premature or preterm means an infant born with a low birth weight, 5.5 pounds or less, or an infant born at 37 weeks or less.

MBO…means a Market-Based Organization or facility of CommonSpirit Health.

Medical Care…means the ordinary and usual professional services rendered by a Physician or other specified Provider during a professional visit for treatment of an Illness or Accidental Injury.

Medical Plan…is a plan sponsored by CommonSpirit Health (fka Catholic Health Initiatives) and its Divisions/Market-Based Organizations (MBOs).

Medically Necessary or Medical Necessity… means that a specific service provided to you is reasonably required, in the reasonable judgment of the Claims Administrator, for the treatment of management of a medical symptom or Condition and that the service provided is the most efficient and economical service which can safely be provided to you. When applied to Hospital Inpatient Services, Medically Necessary means that your medical symptoms or Condition require that the treatment be provided to you as an Inpatient and that treatment cannot safely be provided to you as an Outpatient. Further, Medically Necessary means that Inpatient Hospital care and treatment will not be covered when, in the reasonable judgment of the Claims Administrator, your medical symptoms and Condition no longer necessitate your continued stay in a Hospital. The fact that a Physician or other health care Provider may prescribe, order, recommend, or approve a service or supply does not of itself make such a service Medically Necessary.

Medicare…means the program established by Title XVIII of the Social Security Act (42 U.S.C.§ 395 et seq.).
Medicare Approved or Medicare Participating…means a Provider which has been certified or approved by the Department of Health and Human Services for participating in the Medicare Program.

Medicare Secondary Payer or MSP…means those provisions of the Social Security Act set forth in 42 U.S.C.§ 395 y (b), and the implemented regulations set forth in 42 C.F.R. Part 411, as amended, which regulate the manner in which certain Employers may offer group health care coverage to Medicare-eligible Employees, their Spouses and, in some cases, Dependent Children.

Mental Health Condition…means an Illness Affecting Mental Health.

Mental Health Unit…means a unit established to perform preadmission review and length of stay review for Inpatient and/or Outpatient services for the treatment of Illness Affecting Mental Health and Substance Abuse.

Out-of-Network Provider…means a Hospital, Professional Provider, or facility which does not have a written agreement with the Claims Administrator to provide services to Participants. Costs for services received from an Out-of-Network Provider/facility are based on a percentage of the Medicare allowable rate for most services.

Occupational Therapist…means a duly licensed occupational therapist.

Occupational Therapy…means constructive therapeutic activity designed and adapted to promote the restoration of useful physical function. Occupational Therapy does not include educational training or services designed and adapted to develop a physical function.

Optometrist…means a duly licensed optometrist.

Organized Health Care Arrangement…means this Plan and each other health plan maintained by the Plan Sponsor, including the insurers that provide Benefits under any such plan.

Orthotic Provider…means a duly licensed orthotic Provider.

Out-of-Pocket Maximum…means the maximum amount you are required to pay in a Benefit Year for Eligible Medical and Prescription Charges for your Copayments, Coinsurance and Deductible. The Out-of-Pocket Maximum does not include penalties and charges that are ineligible for reimbursement.

Outpatient…means that you are receiving treatment while not an Inpatient. Services considered Outpatient include, but are not limited to, services in an Emergency room regardless of whether you are subsequently registered as an Inpatient in a health care facility.

Outpatient Facility…means a duly licensed facility other than a doctor's, physical therapist's or midwife's office that provides Outpatient services for treatment of an Illness or Accident, other than for Illness Affecting Mental Health or Substance Abuse.

Palliative Care…means reduction or abatement of pain and other troubling symptoms through services provided by members of the Hospice team of Providers.

Partial Hospitalization Treatment Program…means a Claims Administrator approved planned program of a Hospital or Substance Use Disorder Treatment Facility for the treatment of Illness Affecting Mental Health or Substance Use Disorder Treatment in which patients spend days or nights.

Participant or **Plan Participant**…means a person covered under this Plan.

Permitted Disclosures…means any disclosure for purposes of payment, treatment, or health care operations of a plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Permitted Uses…means any payment, treatment, or health care operation of the Plan or its Organized Health Care Arrangement as defined in HHS Reg. §164.501.

Pharmacist…means a duly licensed Pharmacist.

Pharmacy…means any licensed establishment in which the profession of Pharmacy is practiced.

Physical Therapist…means a duly licensed physical therapist.

Physical Therapy…means the treatment of a disease, injury, or Condition by physical means by a Physician or a registered profession physical therapist under the supervision of a Physician and which is designed and adapted to promote the restoration of a useful physical function. Physical Therapy does not include educational training or services designed and adapted to develop a physical function.

Physician…means a Physician duly licensed to practice medicine in all of its branches.

Physician Assistant…means a duly licensed Physician Assistant performing under the direct supervision of a Physician, Dentist, or Podiatrist and billing under such Provider.

Plan…means the Medical Plan.

Plan Administrator…means CommonSpirit Health.

Plan Administration Functions…means administration functions performed by Plan Sponsor personnel on behalf of a plan and excludes functions performed by the Plan Sponsor in connection with any other Benefit or Benefit plan of the Plan Sponsor.

Plan Sponsor…means CommonSpirit Health.

Podiatrist…means a duly licensed podiatrist.

Post-Service Claim…means any claim for a Benefit under the Medical Plan that is not a Pre-Service Claim.

Prescription Drug…means a drug that bears the legend, “Caution, Federal Law prohibits dispensing without a prescription and meets the following criteria:

- Prescribed by a Provider who is legally authorized to prescribe;
- Dispensed by a recognized licensed retail Pharmacy, a contracting specialty Pharmacy,or through the home delivery drug program; and
- Is Medically Necessary for your Illness or Accidental Injury or is approved for Preventiveor Wellness Care.

Covered drugs are limited to those taken orally, absorbed through the skin, and certain injected Prescription Drugs. Devices and implants are not considered to be Prescription Drugs.

Pre-Service Claim…means any Claim for a Benefit under the Medical Plan which is made in advance of obtaining the requested services or supplies.

Preventive Care or Preventive Care Services…means history and physical examinations, routine laboratory services, immunizations, routine history and gynecological exams, and well-child care, including age-appropriate pediatric preventive services, as defined by current recommendations for Preventive Pediatric Health Care of the American Academy of Pediatrics. Pediatric preventive services shall include, at minimum, a history and complete physical examination, as well as developmental assessment, anticipatory guidance, immunizations, and laboratory services including, but not limited to, screening for lead exposure as well as blood levels.

Primary Care Physician…means a general practitioner, family practitioner (family practice Physician), doctor of internal medicine (internist), pediatrician, doctor of obstetrics/gynecology, nurse practitioner, Registered Nurse, nurse-midwife, or Physician Assistant.

Prior Authorization…means the process of obtaining approval as to appropriateness of a medication before it is actually dispensed and utilized.

Privacy Officer…means the CommonSpirit Health Privacy Officer.

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

Prosthetic Provider…means a duly licensed prosthetic Provider.

Protected Health Information…means information including demographic information collected from an individual, that is created or received by a plan and that is transmitted or maintained in any medium (including verbally) that

- Relates to the past, present, or future physical or mental health Condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and
- That identifies the individual or with respect to which there is a reasonable basis to believe the information can be used to identify the individual.

Protected Health Information shall not include information that is de-identified in accordance with HHS Reg. §164.514(a).

Protected Health Information also includes genetic information. Genetic information is information about an individual's family members, and the manifestation of a disease or disorder in the individual's family members. Family members include dependents and any other individual who is a first-, second-, third-, or fourth-degree relative of the individual or the individual's Dependents.

Provider or Professional Provider…means a duly licensed provider designated by the Medical Plan to render Covered Services or Supplies to you as a Provider. For the services of these Providers to be covered, the service must meet the definition of Covered Services or Supplies, and the Provider must be providing the services or supplies within the scope of his or her license or certification.

Provider does not include athletic trainers; boarding houses; camps or schools; convalescent facilities, institutions for chronic care, personal care, residential or domiciliary care, or homes for the aged; dental assistants and dental hygienists; education or training programs; halfway houses; health resorts; health spas; hypnotists; homeopathic medical Providers, hotels, motels and other lodging; priests, and other religious affiliates; naturopaths; opticians; orthodontists; residential treatment centers; residents, interns, or other Employees of Hospitals or Skilled Nursing Facilities who bill for their services and are not listed as Covered Providers; rest homes; sanitariums; and other non-traditional medical Providers; transportation other than by Ambulance; and any facilities or Providers not specifically mentioned within this SPD that are not specifically designated by CommonSpirit Health to be eligible providers.

Psychologist…means a Registered Clinical Psychologist.

Prudent Layperson…means a person who possesses an average knowledge of health and medicine.

Qualified Exigency…means, as defined by the Department of Labor for purposes of the Family and Medical Leave Act, an Emergency arising out of one of the following categories:

- Short-notice deployment;
- Military events and related activities;
- Childcare and school activities;
- Financial and legal arrangements;
- Counseling;
- Rest and Recuperation;
- Post-deployment activities; and
- Additional activities not encompassed in the other categories but agreed to by the Employer and Employee.

Qualified Life Event…means a life event such as:

- Marriage;
- Divorce, legal separation or annulment;
- Birth of a Child, adoption, placement for adoption, or Legal Guardianship;
- Change of a Child's eligibility status due to reaching the maximum age;
- Loss of Legal Guardianship;
- Death of a Child or Spouse;
- Changes in your work status that affect eligibility for Benefits;
- Changes in a Spouses work status affecting eligibility for Benefits;
- Gaining or losing eligibility for another plan such as expiration of COBRA coverage from another Employer's plan, gaining or losing eligibility for Medicare or Medicaid;
- Gaining or losing eligibility for the Medicaid or state Children's Health Insurance Program (CHIP); or
- Qualified Medical Child Support Order requiring you or your Spouse to provide health coverage for a Dependent.

Since this Plan is funded in part by pre-tax Employee contributions, it is governed by IRS regulations that indicate that a Participant may only change his or her Benefit Plan elections during Annual Benefit Enrollment unless there is a Qualified Life Event, and that the change elected must be consistent with the Qualified Life Event. All changes must be elected within 31 days of the Qualified Life Event. However, if the requested election change results from birth, adoption, or placement for adoption of a dependent child, or gaining or losing eligibility for Medicaid or state CHIP, the change must be elected within 60 days of the applicable event. All requested election changes will be effective the first of the month following the date of notification to CommonSpirit Health of the Qualified Life Event.

Qualified Medical Child Support Order or QMCSO…means a medical Child support order, qualifying under ERISA and approved by the Plan Administrator that provides for health care coverage and allocation of responsibility for the payment of costs for health care coverage for a natural or adopted Child of an Employee or Spouse.

Registered Dietician…means a duly licensed registered dietitian.
Registered Nurse (RN) or Licensed Practical Nurse (LPN)…means a person duly licensed to practice nursing.

Registered Surgical Assistant…means a duly licensed certified surgical assistant, certified surgical technician, surgical assistant certified, or Registered Nurse first assistant.

Related Professional Services…means services that are provided at the same time as the office visit (e.g., lab work done while in the doctor's office).

Renal Dialysis Treatment…means one unit of service, including the equipment, supplies, and administrative services which are customarily considered a necessary to perform the dialysis process.

Residential Treatment Facilities…means a duly licensed facility that treats an intermediate level of Substance Use Disorder on both an inpatient and outpatient basis. It provides a detailed regimen that includes full-time residence and full-time participation by the patient within a residential treatment facility which provides room and board, evaluation and diagnosis, counseling, referral and orientation to specialized community resources.

Skilled Nursing Facility…means an institution or a distinct part of an institution which is primarily engaged in providing comprehensive skilled services and rehabilitative Inpatient care and is duly licensed by the appropriate governmental authority to provide such services.

Skilled Nursing Service…means those services provided by a Registered Nurse (R.N.) or licensed practical nurse (L.P.N.) which require the clinical skill and professional training of an R.N. or L.P.N. and which cannot reasonably be taught to a person who does not have specialized skill and professional training. Benefits for Skilled Nursing Service will not be provided due to the lack of willing or available non-professional personnel. Skilled Nursing Service does not include Custodial Care Service.

Specialist…means any Physician other than a Primary Care Physician who is classified as a Specialist by the American Boards of Medical Specialties; or who is designated by the Plan as a Specialist Physician.

Specialty Drug…means drugs that are typically used for treating or managing chronic Illnesses. These drugs often require special handling (e.g., refrigeration) and administration. Some Specialty Drugs may be taken orally, but others may require administration by injection, infusion, or inhalation. Specialty Drugs may not be available from a retail Pharmacy.

Speech Therapist…means a duly licensed Speech Therapist.

Speech Therapy…means the treatment for the correction of a speech impairment resulting from disease trauma, congenital anomalies, or previous therapeutic processes and which is designed and adapted to promote the restoration of a useful physical function. Speech Therapy does not include educational training or services designed and adapted to develop a physical function.

Spouse…means a person who is legally married under the laws of the state where the marriage was celebrated to an employee who is participating in the health care benefits offered by CommonSpirit Health, regardless of where that couple currently resides.

Step Therapy or Step Therapy Program…means the program which requires you to first try one or more specified drugs to treat a particular Condition before the Plan will cover another (usually more expensive) drug that your Physician may have prescribed.

Substance Use Disorder…means the uncontrollable or excessive abuse of addictive substances consisting of alcohol, morphine, cocaine, heroin, opium, cannabis, and other barbiturates, amphetamines, tranquilizers, and/or hallucinogens, and the resultant physiological and/or psychological dependency which develops with continued use of such addictive substances requiring Medical Care as determined by a Physician or Psychologist.

Substance Use Disorder Treatment…means an organized, intensive, structured, rehabilitative treatment program of either a Hospital or Substance Use Disorder Treatment Facility. It does not include programs consisting primarily of counseling by individuals other than a Physician or Psychologist, court-ordered evaluations, programs which are primarily for diagnostic evaluations, mental retardation, or learning disabilities, care in lieu of detention or correctional placement or family retreats.

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

Summary Health Information…means information that summarizes the Claims history, Claims expense or types of Claims experience by an individual for whom Benefits are or were provided under the Plan, provided that individual identifying information has been deleted.

Summary Plan Description or SPD…means this booklet which describes the features of this Benefit Plan.

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

Suspected Breach…means the suspected unauthorized acquisition, access, use, or disclosure of Unsecured PHI.

Temporomandibular Joint Dysfunction (TMJ) and Related Disorders…means jaw joint Conditions including temporomandibular joint disorders and craniomandibular disorders, and all other Conditions of the joint linking the jawbone and skull and the complex muscles, nerves, and other tissues relating to that joint.

Terminally Ill…means a person has a life expectancy of six months or less because of a chronic, progressive Illness that is incurable according to the person's doctor.

Unsecured PHI…means Personal Health Information (PHI) that has not been rendered unusable, unreadable, or indecipherable to unauthorized individuals through the use of one of the following technologies or methodologies:

- Encryption: Electronic PHI has been encrypted by the use of an algorithmic process to transform data into a form in which there is a low probability of assigning meaning without use of a confidential process or key and such confidential process or key that might enable decryption has not been breached. (See encryption processes identified by HHS as having been tested by the National Institute of Standards and Technology (NIST) and judged to meet this standard.)
- Destruction: The media on which the PHI is stored or recorded has been destroyed in one of the following ways:
- Paper, film, or other hard copy media have been destroyed such that PHI cannot be read or otherwise cannot be reconstructed.
- Electronic media have been cleared, purged, or destroyed consistent with NIST Special Publication 800-88, Guidelines for Media Sanitization, such that the PHI cannot be retrieved.
- Any other technology or methodology specified by the Secretary of Health and Human Services for this purpose.

Urgent Care Facility…means a duly licensed Urgent Care Facility.

Urgent Pre-Service Claim or Appeal…means a review request that is expedited due to life changing or life-threatening circumstances for pre-service approval. The review takes 72 hours. You may be eligible for an expedited external review if you have a medical condition in which the normal timeframe for a standard external review or an expedited internal appeal could:

- Seriously jeopardize your life or health; or
- Your request involves an admission or continued stay, or health care service for which you received emergency services but have not yet been released.

You might also qualify for an expedited appeal if your request involves an experimental or investigation determination and your health care provider certifies in writing that the service/treatment would be significantly less effective if not promptly initiated.

Workforce Member…means employees, volunteers, trainees, and other persons whose conduct, in the performance of work for an entity, is under the direct control of such entity, whether or not they are paid by such entity.

Eligibility Addendum

Initial eligibility requirements and effective date of coverage for employees vary by Market-Based Organization (MBO). All other eligibility provisions are determined by the Plan Administrator and are consistent across all MBOs and National offices. All MBOs have a Benefit Year beginning on January 1 and ending on December 31.

Unless otherwise indicated, **Benefits will begin based on your local waiting period. If you have questions, please contact your local Human Resources.** Hours listed are per pay period and are the regularly scheduled hours as reflected in the payroll system as the full-time equivalent or FTE. Where an employee holds more than one position with the Employer, the regularly scheduled hours will be added together for purposes of establishing the FTE for the purpose of benefits eligibility. An Employee's FTE will be evaluated and updated periodically throughout the year.

Market-based organization (MBO) or CommonSpirit Facility	City	State	FT Hrs	PT Hrs
Sisters of Charity of Cincinnati	Cincinnati	OH	60	32

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Effective January 1, 2024