PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION
FOR
St. Francis Health Services
PREVENTIVE MEDICAL SERVICES PLAN
EFFECTIVE 1/1/2015
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Introduction

Welcome to the St. Francis Health Services Plan. This document is a summary of your Preventive medical benefits, including information on eligibility requirements, termination, COBRA, and what to do if you don’t agree with the way a claim was processed. Please feel free to call HealthEZ with any questions on these benefits.

Introduction and Purpose
The Plan Sponsor has established the Plan for the benefit of eligible Employees, in accordance with the terms and conditions described herein. Plan benefits may be self-funded through a benefit fund or a trust established by the Plan Sponsor and self-funded with contributions from Participants and/or the Plan Sponsor, or may be funded solely from the general assets of the Plan Sponsor. Participants in the Plan may be required to contribute toward their benefits.

The Plan Sponsor’s purpose in establishing the Plan is to help offset, for eligible Employees, the economic effects arising from seeking Preventive Health Services. To accomplish this purpose, the Plan Sponsor must be cognizant of the necessity of containing health care costs through effective plan design, and of abiding by the terms of the Plan Document, to allow the Plan Sponsor to allocate the resources available to help those individuals participating in the Plan to the maximum feasible extent.

The purpose of this Plan Document is to set forth the terms and provisions of the Plan that provide for the payment or reimbursement of all or a portion of certain expenses for Preventive medical charges. The Plan Document is maintained by St. Francis Health Services and may be inspected at any time during normal working hours by any Participant.

General Plan Information

Patient Protection and Affordable Care Act

Name of Plan: St. Francis Health Services Preventive Medical Services Plan

Plan Sponsor: St. Francis Health Services, 801 Nevada Ave Morris, MN 56267

Plan Administrator:
(Named Fiduciary) St. Francis Health Services, 801 Nevada Ave Morris, MN 56267

Plan Sponsor ID No. (EIN): 41-1484416

Source of Funding: Self-Funded

Applicable Law: ERISA

Plan Year: January 1st to December 31st

Plan Number: 502

Plan Status: Non-Grandfathered

Plan Type: Preventive Medical Services Preventive Prescription Drug
Establishment of the Plan; Adoption of the Plan Document and Summary Plan Description

THIS PLAN DOCUMENT AND SUMMARY PLAN DESCRIPTION, made by St. Francis Health Services (the “Company” or the “Plan Sponsor”) as of (DATE), hereby sets forth the provisions of the St. Francis Health Services Preventive Medical Services Plan (the “Plan”).

Effective Date
The Plan Document is effective as of the date first set forth above, and each amendment is effective as of the date set forth therein, or on such other date as specified in an applicable collective bargaining agreement (if any) with respect to the Employees covered by such agreement (the “Effective Date”).

Adoption of the Plan Document
The Plan Sponsor, as the settlor of the Plan, hereby adopts this non-grandfathered Plan Document as the written description of the Plan. This Plan Document represents both the Plan Document and the Summary Plan Description, which is required by the Employee Retirement Income Security Act of 1974, 29 U.S.C. et seq. (“ERISA”). This Plan Document amends and replaces any prior statement of the health care coverage contained in the Plan or any predecessor to the Plan.

IN WITNESS WHEREOF, the Plan Sponsor has caused this Plan Document to be executed.

St. Francis Health Services

By: ____________________________
Name: Leah C. Nelson

Date: 3/31/2015
Title: Director of HR
Legal Entity; Service of Process
The Plan is a legal entity. Legal notice may be filed with, and legal process served upon, the Plan Administrator.

Not a Contract
This Plan Document and any amendments constitute the terms and provisions of coverage under this Plan. The Plan Document shall not be deemed to constitute a contract of any type between the Company and any Participant or to be consideration for, or an inducement or condition of, the employment of any Employee. Nothing in this Plan Document shall be deemed to give any Employee the right to be retained in the service of the Company or to interfere with the right of the Company to discharge any Employee at any time; provided, however, that the foregoing shall not be deemed to modify the provisions of any collective bargaining agreements which may be entered into by the Company with the bargaining representatives of any Employees.

Mental Health Parity
Pursuant to the Mental Health Parity and Addiction Equity Act of 2008, this Plan applies its terms uniformly and enforces parity between covered Preventive health care benefits and covered Preventive mental health and substance abuse disorder screening and counseling benefits relating to financial cost sharing restrictions and treatment duration limitations. For further details, please contact the Plan Administrator.

Applicable Law
This is a self-funded benefit plan coming within the purview of the Employee Retirement Income Security Act of 1974 ("ERISA"). The Plan is funded with employee and/or employer contributions. As such, when applicable, Federal law and jurisdiction preempt State law and jurisdiction.

Discretionary Authority
The Plan Administrator shall have sole, full and final discretionary authority to interpret all Plan provisions, including the right to remedy possible ambiguities, inconsistencies and/or omissions in the Plan and related documents; to make determinations in regards to issues relating to eligibility for benefits; to decide disputes that may arise relative to a Plan Participants' rights; and to determine all questions of fact and law arising under the Plan.

Claims Administrator Is Not a Fiduciary
A Claims Administrator is not a fiduciary under the Plan by virtue of paying claims in accordance with the Plan's rules as established by the Plan Administrator.

Plan Is Not An Employment Contract.
The Plan is not to be construed as a contract for or of employment.

Type of Administration
The Plan is a self-funded group health Plan and the administration is provided through a Third Party Claims Administrator. The funding for the benefits is derived from the funds of the Employer and contributions made by covered Employees. The Plan is not insured.

Thank you,
The team at HealthEZ
Your Benefits

Here is an outline of the requirements for your benefits. These will be referenced throughout the document, but we like to put them in one spot so you can find them quickly.

<table>
<thead>
<tr>
<th>Eligibility</th>
</tr>
</thead>
<tbody>
<tr>
<td>Waiting Period</td>
</tr>
<tr>
<td>First of the month following 60 days of hire</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>First day of the month following 30 days of incurring a change in status</td>
</tr>
<tr>
<td>Full Time Requirements</td>
</tr>
<tr>
<td>56 hours per pay period (Bi-weekly)</td>
</tr>
</tbody>
</table>

1. An Employee's lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, "marriage or married" means a legal union; and

2. An Employee's Domestic Partner who has the same principal place of abode for more than two years, and who relies on the employee for more than half of his or her support for the calendar year in which the Domestic Partner is enrolled for coverage under the Plan.

3. An Employee's Child who is less than 26 years of age; and

4. An Employee's Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

In addition, we can offer an updated definition of Child for the review of the Plan:

"Child"

"Child" shall mean, in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

"Dependent" does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.
<table>
<thead>
<tr>
<th>Termination</th>
<th>Last day of the month when no longer under an eligible class.</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;However, conditions may change and St. Francis Health Services, reserves the right to amend or terminate the plan at any time.&quot;</td>
<td></td>
</tr>
<tr>
<td>Dependent Termination</td>
<td>Last day of the month when no longer under an eligible class.</td>
</tr>
<tr>
<td>Are grandchildren covered?</td>
<td>No</td>
</tr>
<tr>
<td>Plan Year</td>
<td>Calendar</td>
</tr>
</tbody>
</table>
Your Medical Plan

This document is a description of St. Francis Health Services Preventive Medical Services Plan (the Plan). This is the final version of your benefits – no oral interpretations can change this plan.

Coverage under the Plan will take effect for an eligible Employee and designated Dependents when the Employee and such Dependents satisfy the Waiting Period and all the eligibility requirements of the Plan.

This Plan may be amended in writing and these amendments may change any part of the Plan.

Failure to follow the eligibility or Enrollment Requirements of this Plan may result in delay of coverage or no coverage at all. Reimbursement from the Plan can be reduced or denied because of certain provisions in the Plan, such as exclusions, and timeliness of COBRA elections, lack of timely filing of claims or lack of coverage.

The Plan will pay for expenses incurred while you are a covered plan member. It does not cover expenses incurred before coverage began or after coverage terminated. An expense for a service is incurred on the date the service is furnished.

No action at law or in equity shall be brought to recover under any section of this Plan until the appeal rights provided have been exercised and the Plan benefits requested in such appeals have been denied in whole or in part.

If the Plan is terminated, amended, or benefits are eliminated, the rights of Covered Persons are limited to Covered Charges incurred before termination, amendment or elimination.

Sections

This document summarizes the Plan rights and benefits for covered Employees and their Dependents and is divided into the following parts:

Eligibility, Funding, Effective Date and Termination. Explains eligibility for coverage under the Plan, funding of the Plan and when the coverage takes effect and terminates.

Schedule of Benefits. Provides an outline of the Plan reimbursement formulas as well as payment limits on certain services.

Benefit Descriptions. Explains when the benefit applies and the types of charges covered.

Defined Terms. Defines those Plan terms that have a specific meaning.

Plan Exclusions. Shows what charges are not covered.


Continuation Coverage Rights Under COBRA. Explains when a person's coverage under the Plan ceases and the continuation options which are available.

ERISA Information. Explains the Plan's structure and the Participants' rights under the Plan.
Eligibility, Funding, Effective Date and Termination Provisions

If you have any questions about your plan or any of the benefits do not hesitate to contact HealthEZ, free of charge.

ELIGIBILITY

Eligible Classes of Employees. All Active Full-Time Employees of the Employer.

Eligibility Requirements for Employee Coverage. A person is eligible for Employee coverage from the first day that he or she:

1. is a Full-Time Active Employee of the Employer as defined in the Your Benefits table in the Introduction section.

2. is in a class eligible for coverage.

3. completes the employment Waiting Period mentioned in the Your Benefits table in the Introduction section. A “Waiting Period” is the time between the first day of employment and the first day of coverage under the Plan.

Eligible Classes of Dependents. A Dependent is any one of the following persons:

- An Employee’s lawfully married spouse possessing a marriage license who is not divorced from the Employee. For purposes of this section, “marriage or married” means a legal union; and

- An Employee’s Domestic Partner who has the same principal place of abode for more than two years, and who relies on the employee for more than half of his or her support for the calendar year in which the Domestic Partner is enrolled for coverage under the Plan.

- An Employee’s Child who is less than 26 years of age; and

- An Employee’s Child, regardless of age, who was continuously covered prior to attaining the limiting age under the bullets above, who is mentally or physically incapable of sustaining his or her own living. Such Child must have been mentally or physically incapable of earning his or her own living prior to attaining the limiting age under the bullets above. Written proof of such incapacity and dependency satisfactory to the Plan must be furnished and approved by the Plan within 31 days after the date the Child attains the limiting age under the bullets above. The Plan may require, at reasonable intervals, subsequent proof satisfactory to the Plan during the next two years after such date. After such two year period, the Plan may require such proof, but not more often than once each year.

In addition, we can offer an updated definition of Child for the review of the Plan:

“Child”

“Child” shall mean, in addition to the Employee’s own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee’s Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an “eligible foster child,” which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

“Dependent” does not include any person who is a member of the armed forces of any Country or who is a resident of a Country outside the United States.

The Plan reserves the right to require documentation, satisfactory to the Plan Administrator, which establishes a Dependent relationship.
Eligibility Requirements for Dependent Coverage. A family member of an Employee will become eligible for Dependent coverage on the first day that the Employee is eligible for Employee coverage and the family member satisfies the requirements for Dependent coverage.

At any time, the Plan may require proof that a Spouse or a child qualifies or continues to qualify as a Dependent as defined by this Plan.

2009 Special Enrollment Rights under CHIP

If an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse) because of coverage under Medicaid or the Children's Health Insurance Program, there may be a right to enroll in this Plan if there is a loss of eligibility for the government-provided coverage. However, a request for enrollment must be made within 60 days after the government-provided coverage ends.

In addition, if an Employee has declined enrollment in the Plan for him or herself or his or her dependents (including a Spouse), and later becomes eligible for state assistance through a Medicaid or Children's Health Insurance Program which provides help with paying for Plan coverage, then there may be a right to enroll in this Plan. However, a request for enrollment must be made within 60 days after the determination of eligibility for the state assistance.

If you have any questions regarding the application of this provision to you, contact the Plan Administrator.

FUNDING

Cost of the Plan. St. Francis Health Services shares the cost of Employee and Dependent coverage under this Plan with the covered Employees. The enrollment application for coverage will include a payroll deduction authorization. This authorization must be filled out, signed and returned with the enrollment application.

The level of any Employee contributions is set by the Plan Administrator. The Plan Administrator reserves the right to change the level of Employee contributions.

ENROLLMENT

Enrollment Requirements. An Employee must enroll for coverage by filling out and signing an enrollment application along with the appropriate payroll deduction authorization. If the covered Employee already has Dependent coverage, a newborn child will be automatically enrolled for 30 days from birth; otherwise, separate enrollment for a newborn child is required.

Enrollment Requirements for Newborn Children.

A newborn child, a child placed for adoption, or a newly-adopted child of a covered participant will be covered from the moment of birth, placement for adoption, or adoption provided the child is properly enrolled as a dependent of the participant within 30 days of the child's date of birth, adoption, or placement for adoption.

Charges for covered routine Preventive Physician care will be applied toward the Plan of the covered parent. If the newborn child is not enrolled in this Plan on a timely basis, there will be no payment from the Plan and the covered parent will be responsible for all costs.

If the child is not enrolled within 30 days of birth, the enrollment will be considered a Late Enrollee and will not be eligible for coverage until the next annual Open Enrollment Period.
TIMELY OR LATE ENROLLMENT

(1) **Timely Enrollment** - The enrollment will be "timely" if the completed form is received by the Plan Administrator no later than 30 days after the person becomes eligible for the coverage, either initially or under a Special Enrollment Period. If two Employees (husband and wife) are covered under the Plan and the Employee who is covering the Dependent terminates coverage, the Dependent coverage may be continued by the other covered Employee with no Waiting Period as long as coverage has been continuous.

(2) **Late Enrollment** - An enrollment is "late" if it is not made on a "timely basis" or during a Special Enrollment Period. Late Enrollees will not be eligible for coverage until the next annual Open Enrollment Period.

SPECIAL ENROLLMENT RIGHTS

Federal law provides Special Enrollment provisions under some circumstances. If an Employee is declining enrollment for himself or his dependents (including their spouse) because of other health insurance or group health plan coverage, there may be a right to enroll in this Plan if there is a loss of eligibility for that other coverage (or if the employer stops contributing towards the other coverage). However, a request for enrollment must be made within 30 days after the coverage ends (or after the employer stops contributing towards the other coverage).

In addition, in the case of a birth, marriage, adoption or placement for adoption, there may be a right to enroll in this Plan. However, a request for enrollment must be made within 30 days after the birth, marriage, adoption or placement for adoption.

SPECIAL ENROLLMENT PERIODS

The Enrollment Date for anyone who enrolls under a Special Enrollment Period is the first date of coverage. Thus, the time between the date a special enrollee first becomes eligible for enrollment under the Plan and the first day of coverage is not treated as a Waiting Period.

(1) **Individuals losing other coverage.** An Employee or Dependent, who is eligible, but not enrolled in this Plan, may enroll if each of the following conditions is met:

- (a) The Employee or Dependent was covered under a group health plan or had health insurance coverage at the time coverage under this Plan was previously offered to the individual;

- (b) If required by the Plan Administrator, the Employee stated in writing at the time that coverage was offered that the other health coverage was the reason for declining enrollment;

- (c) The coverage of the Employee or Dependent who had lost the coverage was under COBRA and the COBRA coverage was exhausted, or was not under COBRA and either the coverage was terminated as a result of loss of eligibility for the coverage (including as a result of legal separation, divorce, death, termination of employment or reduction in the number of hours of employment) or employer contributions towards the coverage were terminated and,

- (d) The Employee or Dependent requests enrollment in this Plan not later than 31 days after the date of exhaustion of COBRA coverage or the termination of coverage or employer contributions, described above. Coverage will begin no later than the first day of the first calendar month following the date the completed enrollment form is received.

If the Employee or Dependent lost the other coverage as a result of the individual's failure to pay premiums or required contributions or for cause (such as making a fraudulent claim), that individual does not have a Special Enrollment right.

(2) **Dependent beneficiaries.** If:

- (a) The Employee is a participant under this Plan (or has met the Waiting Period applicable to becoming a participant under this Plan and is eligible to be enrolled under this Plan but for a failure to enroll during a previous enrollment period), and
(b) A person becomes a Dependent of the Employee through marriage, birth, adoption or placement for adoption,

then the Dependent (and if not otherwise enrolled, the Employee) may be enrolled under this Plan as a covered Dependent of the covered Employee. In the case of the birth or adoption of a child, the Spouse of the covered Employee may be enrolled as a Dependent of the covered Employee if the Spouse is otherwise eligible for coverage. If the Employee is not enrolled at the time of the event, the Employee must enroll under this Special Enrollment Period in order for his eligible Dependents to enroll.

The Dependent Special Enrollment Period is a period of 30 days and begins on the date of the marriage, birth, adoption or placement for adoption. To be eligible for this Special Enrollment, the Dependent and/or Employee must request enrollment during this 30-day period.

The coverage of the Dependent enrolled in the Special Enrollment Period will be effective:

(a) in the case of marriage, as of the date of marriage; or

(b) in the case of a Dependent's birth, as of the date of birth; or

(c) in the case of a Dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

(d) Proof of marriage may be required.

In Addition, an employee who is already enrolled in a benefit package may enroll in another benefit package under the plan if a dependent of that employee has a Special Enrollment right because the dependent lost eligibility for other coverage.

a. If a qualified beneficiary moves out of his or her HMO service area, an alternative plan may be elected.

EFFECTIVE DATE

Effective Date of Employee Coverage. Coverage begins on the date assigned; this is on the coversheet at the beginning of this document. You must meet the following three requirements:

(1) The Eligibility Requirement;

(2) The Active Employee Requirement; and,

(3) The Enrollment Requirements of the Plan.

Active Employee Requirement.

An Employee must be an Active Employee (as defined by this Plan) for this coverage to take effect.

Effective Date of Dependent Coverage. A Dependent's coverage will take effect on the day that the Eligibility Requirements are met; the Employee is covered under the Plan; and all Enrollment Requirements are met.
TERMINATION OF COVERAGE

When coverage under this Plan stops, Plan Participants will receive a certificate that will show the period of coverage under this Plan. Please contact the Plan Administrator for further details.

The Employer or Plan has the right to rescind any coverage of the Employee and/or Dependents for cause, including but not limited to making a fraudulent claim or an intentional material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan. The Employer or Plan may either void coverage for the Employee and/or covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan’s discretion, or may immediately terminate coverage. The employer will refund all contributions paid for any coverage rescinded; however, claims paid will be offset from this amount. The employer reserves the right to collect additional monies if claims are paid in excess of the Employee’s and/or Dependent’s paid contributions.

Plan Notice of Reduction or Termination. If the Plan Administrator is notifying the Participant of a reduction or termination of a course of treatment (other than by Plan amendment or termination), before the end of such period of time or number of treatments. The Participant will be notified sufficiently in advance of the reduction or termination to allow the Participant to appeal and obtain a determination on review of that adverse benefit determination before the benefit is reduced or terminated. This rule does not apply if benefits are reduced or eliminated due to plan amendment or termination. A similar process applies for claims based on a rescission of coverage for fraud or misrepresentation.

When Employee Coverage Terminates. Employee coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Employee may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):

(1) The date the Plan is terminated;
(2) The last day of the calendar month in which the covered Employee ceases to be in one of the Eligible Classes. This includes death or termination of Active Employment of the covered Employee. (See the Continuation Coverage Rights under COBRA);
(3) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;
(4) If an Employee commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the employee and covered Dependents for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan’s discretion, or may immediately terminate coverage.

Continuation during Periods of Employer-Certified Disability, Leave of Absence or Layoff. A person may remain eligible for a limited time if Active Full-Time Employment ceases due to disability, leave of absence or layoff. This continuance will end as follows:

For disability leave only: the date the Employer ends the continuance.

For leave of absence or layoff only: the date the Employer ends the continuance.

While continued, coverage will be that which was in force on the last day worked as an Active Employee. However, if benefits reduce for others in the class, they will also reduce for the continued person.

Continuation during Family and Medical Leave. Regardless of the established leave policies mentioned above, this Plan shall at all times comply with the Family and Medical Leave Act of 1993 as promulgated in regulations issued by the Department of Labor.

During any leave taken under the Family and Medical Leave Act, the Employer will maintain coverage under this Plan on the same conditions as coverage would have been provided if the covered Employee had been continuously employed during the entire leave period.

St. Francis Health Services Plan Document – Preventive Medical Services Plan – Ver. 2014-1
If Plan coverage terminates during the FMLA leave, coverage will be reinstated for the Employee and his or her covered Dependents if the Employee returns to work in accordance with the terms of the FMLA leave. Coverage will be reinstated only if the person(s) had coverage under this Plan when the FMLA leave started, and will be reinstated to the same extent that it was in force when that coverage terminated. For example, Waiting Periods will not be imposed unless they were in effect for the Employee and/or his or her Dependents when Plan coverage terminated.

If an Employee takes a leave of absence that qualifies as a family or medical leave under the Family Medical Leave Act (FMLA) of 1993, the Employee should contact the Plan Administrator in order to discuss his or her continued participation in the Plan during the leave. The Employee may continue to pay for his or her health, dental, disability and any health care expense reimbursement benefits. In general, if Employees take an unpaid FMLA, they may continue to participate in the Plan provided they continue to pay for their benefits. They can elect to pay for their benefits in one of the following three ways:

1. Employees can pay for their benefits on a pre-tax basis by allowing St. Francis Health Services to deduct their required contributions from their paycheck before the leave. (Due to certain tax law restrictions, Employees can only prepay on a pre-tax basis through the end of a Plan Year);
2. Employees can pay for their benefits for the duration of the leave on an after-tax basis by a single lump-sum payment at the beginning of the leave; or,
3. Employees can pay for their benefits on an after-tax basis during the leave by sending their payment to St. Francis Health Services on or before the first of each month of the leave.

Rehiring a Terminated Employee. A terminated Employee who is rehired will be treated as a new hire and be required to satisfy all Eligibility and Enrollment Requirements. However, if the Employee is returning to work directly from COBRA coverage, this Employee does not have to satisfy any employment Waiting Period provision.

Employees on Military Leave. Employees going into or returning from military service may elect to continue Plan coverage as mandated by the Uniformed Services Employment and Reemployment Rights Act under the following circumstances. These rights apply only to Employees and their Dependents covered under the Plan before leaving for military service.

(1) The maximum period of coverage of a person under such an election shall be the lesser of:
    (a) The 24 month period beginning on the date on which the person's absence begins; or
    (b) The day after the date on which the person was required to apply for or return to a position or employment and fails to do so.

(2) A person who elects to continue health plan coverage may be required to pay up to 102% of the full contribution under the Plan, except a person on active duty for 30 days or less cannot be required to pay more than the Employee's share, if any, for the coverage.

(3) An exclusion or Waiting Period may not be imposed in connection with the reinstatement of coverage upon reemployment if one would not have been imposed had coverage not been terminated because of service. However, an exclusion or Waiting Period may be imposed for coverage of any Illness or Injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, the performance of uniformed service.

The Employee may also have continuation rights under USERRA. In general, the Employee must meet the same requirements for electing USERRA coverage as are required under COBRA continuation coverage requirements. Coverage elected under these circumstances is concurrent not cumulative. The Employee may elect USERRA continuation coverage for the Employee and their Dependents. Only the Employee has election rights. Dependents do not have any independent right to elect USERRA health plan continuation.

When Dependent Coverage Terminates. A Dependent's coverage will terminate on the earliest of these dates (except in certain circumstances, a covered Dependent may be eligible for COBRA continuation coverage. For a complete explanation of when COBRA continuation coverage is available, what conditions apply and how to select it, see the section entitled Continuation Coverage Rights under COBRA):
(1) The date the Plan or Dependent coverage under the Plan is terminated;

(2) The date that the Employee’s coverage under the Plan terminates for any reason including death. (See the Continuation Coverage Rights under COBRA);

(3) The date a covered Spouse loses coverage due to loss of dependency status. (See the Continuation Coverage Rights under COBRA);

(4) On the last day of the calendar month that a Dependent child ceases to be a Dependent as defined by the Plan. (See the Continuation Coverage Rights under COBRA);

(5) The end of the period for which the required contribution has been paid if the charge for the next period is not paid when due;

(6) The earliest date the Dependent has a claim that is denied in whole or in part because it meets or exceeds an annual limit on non-essential health benefits; or

(7) If a Dependent commits fraud or makes a material misrepresentation in applying for or obtaining coverage, or obtaining benefits under the Plan, then the Employer or Plan may either void coverage for the Dependent for the period of time coverage was in effect, may terminate coverage as of a date to be determined at the Plan’s discretion, or may immediately terminate coverage.

OPEN ENROLLMENT

Before the end of the current Plan Year, and for a period of no less than 30 days (the annual open enrollment period), covered Employees and their covered Dependents will be able to change some of their benefit decisions based on which benefits and coverage are right for them.

A Plan Participant who fails to make an election during open enrollment will automatically retain his or her present coverage.

Plan Participants will receive detailed information regarding open enrollment from their Employer.
Schedule of Benefits

Verification of Eligibility Phone # 1-844-288-5708

Call this number to verify eligibility for Plan benefits before the charge is incurred.

MEDICAL BENEFITS

All benefits described in this Schedule are subject to the exclusions and limitations described below including, but not limited to, the Plan Administrator's determination that: care and treatment is Preventive services; that charges are Usual and Customary; that services, and care are not Experimental and/or Investigational. The meanings of these capitalized terms are in the Defined Terms section of this document.

The Plan covers preventive and wellness services for eligible adults and children and women’s preventive services in compliance with the Patient Protection and Affordable Care Act of 2010 (PPACA), the regulations promulgated thereunder, and as amended from time to time. In addition to the below, a description of preventive services can be found at: www.healthcare.gov/what-are-my-preventive-care-benefits. Recommended ages, frequency and populations are for example only. Coverage will be in accordance with current recommendations under the PPACA or, if none, with reasonable medical judgment. Unless otherwise noted, frequency will be presumed to be annual.

The Plan is a plan which contains a Network Provider Organization.

PPO name: As Listed on ID Card

This Plan has entered into an agreement with certain Hospitals, Physicians and other health care providers, which are called Network Providers. Because these Network Providers have agreed to charge reduced fees to persons covered under the Plan, the Plan can afford to reimburse a higher percentage of their fees.

Therefore, when a Covered Person uses a Network Provider, that Covered Person will receive a higher payment from the Plan than when a Non-network Provider is used. It is the Covered Person's choice as to which Provider to use.

Under the following circumstances, the higher in-Network payment will be made for certain non-Network services:

(1) If a Covered Person has no choice of Network Providers in the specialty that the Covered Person is seeking within the PPO service area.

Additional information about this option, as well as a list of Network Providers will be given to covered Employees and updated as needed.
Claims Audit

The Plan Administrator may use its discretionary authority to utilize a claim audit program or service for a complete claim. While every claim may not be subject to a bill review or audit, the Plan Administrator has the sole discretionary authority for selection of claims subject to review or audit.

The analysis will be employed to identify charges billed in error and/or charges that are not Usual and Customary and/or Preventive Services and may include a patient medical billing records review and/or audit of the patient’s medical charts and records.

Upon completion of an analysis, a report will be submitted to the Plan Administrator or its agent to identify the charges deemed in excess of the Usual and Customary and Reasonable amounts or other applicable provisions, as outlined in this Plan Document.

Despite the existence of any agreement to the contrary, the Plan Administrator has the discretionary authority to reduce any charge to a Usual and Customary and Reasonable charge, in accord with the terms of this Plan Document.
### Schedule of Benefits
#### PREVENTIVE SERVICES PLAN

<table>
<thead>
<tr>
<th></th>
<th>In Network</th>
<th>Out of Network</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Deductible</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Coverage</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>NONE</td>
<td>NONE</td>
</tr>
<tr>
<td><strong>Member Coinsurance</strong></td>
<td>No member responsibility</td>
<td>NO COVERAGE</td>
</tr>
<tr>
<td><strong>Out-of-pocket maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual Coverage</td>
<td>NONE</td>
<td>UNLIMITED</td>
</tr>
<tr>
<td>Family Coverage</td>
<td>NONE</td>
<td>UNLIMITED</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Grandfathered status</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Unlimited</td>
<td>Not grandfathered</td>
<td>% indicates member responsibility.</td>
</tr>
</tbody>
</table>

#### Preventive Services for Children

<table>
<thead>
<tr>
<th>Service</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alcohol and Drug Use</td>
<td>Assessments</td>
</tr>
<tr>
<td>Autism</td>
<td>Screening for children limited to two screenings up to 24 months</td>
</tr>
<tr>
<td>Behavioral</td>
<td>Assessments for children limited to 5 assessments up to age 17</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Screening</td>
</tr>
<tr>
<td>Cervical Dysplasia</td>
<td>Screening</td>
</tr>
<tr>
<td>Congenital Hypothyroidism</td>
<td>Screening for newborns</td>
</tr>
<tr>
<td>Depression</td>
<td>Screening for adolescents age 12 and older</td>
</tr>
<tr>
<td>Developmental</td>
<td>Screening for children under age 3, and surveillance throughout childhood</td>
</tr>
<tr>
<td>Dystlipidemia</td>
<td>Screening for children</td>
</tr>
<tr>
<td>Fluoride Chemoprevention</td>
<td>Supplements for children without fluoride in their water source when prescribed by a physician</td>
</tr>
<tr>
<td>Gonorrhea</td>
<td>Preventive medication for the eyes of all newborns</td>
</tr>
<tr>
<td><strong>Hearing</strong></td>
<td>Screening for all newborns</td>
</tr>
<tr>
<td><strong>Height, Weight and Body Mass Index</strong></td>
<td>Measurement for children</td>
</tr>
<tr>
<td><strong>Hematocrit or Hemoglobin</strong></td>
<td>Screening for children</td>
</tr>
<tr>
<td><strong>Hemoglobinopathies or Sickle cell</strong></td>
<td>Screening for newborns</td>
</tr>
<tr>
<td><strong>HIV</strong></td>
<td>Screening for adolescents</td>
</tr>
<tr>
<td><strong>Immunizations</strong></td>
<td>Vaccines for children from birth to age – doses, recommended ages and recommended populations vary:</td>
</tr>
<tr>
<td></td>
<td>• Diphtheria, Tetanus, pertussis</td>
</tr>
<tr>
<td></td>
<td>• Haemophilus influenza type b</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis A</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>• Human Papillomavirus</td>
</tr>
<tr>
<td></td>
<td>• Inactivated Poliovirus</td>
</tr>
<tr>
<td></td>
<td>• Influenza (Flu Shot)</td>
</tr>
<tr>
<td></td>
<td>• Measles, Mumps, Rubella</td>
</tr>
<tr>
<td></td>
<td>• Meningococcal</td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal</td>
</tr>
<tr>
<td></td>
<td>• Rotavirus</td>
</tr>
<tr>
<td></td>
<td>• Varicella</td>
</tr>
<tr>
<td><strong>Iron</strong></td>
<td>Supplements for children up to 12 months when prescribed by a physician</td>
</tr>
<tr>
<td><strong>Lead</strong></td>
<td>Screening for children</td>
</tr>
<tr>
<td><strong>Medical History</strong></td>
<td>For all children throughout development</td>
</tr>
<tr>
<td></td>
<td>Ages 0-11 months, 1 to 4 years, 5-10 years, 11-14 years and 15 to 17 years</td>
</tr>
<tr>
<td><strong>Obesity</strong></td>
<td>Screening and counseling</td>
</tr>
<tr>
<td><strong>Oral Health</strong></td>
<td>Risk assessment for young children up to age 10</td>
</tr>
<tr>
<td><strong>Phenylketonuria (PKU)</strong></td>
<td>Screening in newborns</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infection (STI)</strong></td>
<td>Prevention counselling and screening for adolescents</td>
</tr>
<tr>
<td><strong>Tuberculin</strong></td>
<td>Testing for Children</td>
</tr>
<tr>
<td><strong>Vision</strong></td>
<td>Screening for all children under the age of 5</td>
</tr>
<tr>
<td>Preventive Services for Women, Including Pregnant Women</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td><strong>Anemia</strong></td>
<td>Screening on a routine basis for pregnant women</td>
</tr>
<tr>
<td><strong>Bacteriuria</strong></td>
<td>Urinary tract or other infection screening for pregnant women</td>
</tr>
<tr>
<td><strong>BRCA</strong></td>
<td>Counseling and genetic testing for women at higher risk</td>
</tr>
<tr>
<td><strong>Breast Cancer Mammography</strong></td>
<td>Screening every year for women age 40 and over</td>
</tr>
<tr>
<td><strong>Breast Cancer Chemoprevention</strong></td>
<td>Counseling for women</td>
</tr>
<tr>
<td><strong>Breastfeeding</strong></td>
<td>Comprehensive support and counseling from trained providers, as well as access to breastfeeding supplies, for pregnant and nursing women. Non-network services will be payable as network services.</td>
</tr>
<tr>
<td><strong>Cervical Cancer</strong></td>
<td>Screening</td>
</tr>
<tr>
<td><strong>Chlamydia Infection</strong></td>
<td>Screening</td>
</tr>
<tr>
<td><strong>Contraception</strong></td>
<td>Patient education and counseling, not including abortifacient drugs</td>
</tr>
<tr>
<td><strong>Domestic and interpersonal violence</strong></td>
<td>Screening and counseling for all women</td>
</tr>
<tr>
<td><strong>Folic Acid</strong></td>
<td>Supplements for women who may become pregnant when prescribed by a physician</td>
</tr>
<tr>
<td><strong>Gestational diabetes</strong></td>
<td>Screening</td>
</tr>
<tr>
<td><strong>Gonorrhea</strong></td>
<td>Screening for all women</td>
</tr>
<tr>
<td><strong>Hepatitis B</strong></td>
<td>Screening for pregnant women</td>
</tr>
<tr>
<td><strong>Human Papillomavirus (HPV) DNA Test</strong></td>
<td>HPV DNA testing every three years for women with normal cytology results who are 30 or older</td>
</tr>
<tr>
<td><strong>Osteoporosis</strong></td>
<td>Screening over age 60</td>
</tr>
<tr>
<td><strong>Routine prenatal visits</strong></td>
<td>For pregnant women</td>
</tr>
<tr>
<td><strong>Pregnancy Incompatibility</strong></td>
<td>Screening and counseling for all pregnant women and follow-up testing</td>
</tr>
<tr>
<td><strong>Tobacco Use</strong></td>
<td>Screening and interventions for all women, and expedited counseling for pregnant tobacco users</td>
</tr>
<tr>
<td><strong>Sexually Transmitted Infections (STI)</strong></td>
<td>Counseling</td>
</tr>
<tr>
<td><strong>Syphilis</strong></td>
<td>Screening</td>
</tr>
<tr>
<td><strong>Well-women visits</strong></td>
<td>To obtain recommended preventive services</td>
</tr>
<tr>
<td>Service</td>
<td>Description</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>-----------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Abdominal Aortic Aneurysm</td>
<td>One-time screening for age 65-75</td>
</tr>
<tr>
<td>Alcohol Misuse</td>
<td>Screening and counseling</td>
</tr>
<tr>
<td>Aspirin</td>
<td>Use for men ages 45-79 and for women ages 55-79 to prevent Cardiovascular Disease when prescribed by a physician</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td>Screening for all adults</td>
</tr>
<tr>
<td>Cholesterol</td>
<td>Screening for adults</td>
</tr>
<tr>
<td>Colorectal Cancer</td>
<td>Screening for adults starting at age 50 limited to one every 5 years</td>
</tr>
<tr>
<td>Depression</td>
<td>Screening for adults</td>
</tr>
<tr>
<td>Type 2 Diabetes</td>
<td>Screening for adults</td>
</tr>
<tr>
<td>Diet</td>
<td>Counseling for adults</td>
</tr>
<tr>
<td>HIV</td>
<td>Screening for adults</td>
</tr>
<tr>
<td>Immunizations</td>
<td>Vaccines for adults:</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis A</td>
</tr>
<tr>
<td></td>
<td>• Hepatitis B</td>
</tr>
<tr>
<td></td>
<td>• Herpes Zoster (Shingles)</td>
</tr>
<tr>
<td></td>
<td>• Human Papillomavirus</td>
</tr>
<tr>
<td></td>
<td>• Influenza (Flu Shot)</td>
</tr>
<tr>
<td></td>
<td>• Measles, Mumps, Rubella</td>
</tr>
<tr>
<td></td>
<td>• Meningococcal</td>
</tr>
<tr>
<td></td>
<td>• Pneumococcal</td>
</tr>
<tr>
<td></td>
<td>• Tetanus, Diphtheria, Pertussis</td>
</tr>
<tr>
<td></td>
<td>• Varicella</td>
</tr>
<tr>
<td>Obesity</td>
<td>Screening and counseling for all adults</td>
</tr>
<tr>
<td>Sexually Transmitted Infection (STI)</td>
<td>Prevention counseling and screening for adults</td>
</tr>
<tr>
<td>Tobacco Use</td>
<td>Screening for all adults and cessation Interventions</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Screening for all adults</td>
</tr>
<tr>
<td>Prescription Services</td>
<td></td>
</tr>
<tr>
<td>-------------------------------------------------------------------------------------</td>
<td></td>
</tr>
<tr>
<td>Prescription Services (up to 31-day supply)</td>
<td></td>
</tr>
<tr>
<td>Mandatory Generics – Preventive Only as defined by PPACA excluding contraceptives</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>No member responsibility</td>
</tr>
<tr>
<td>Mail Order Prescriptions (up to 90-day supply)</td>
<td></td>
</tr>
<tr>
<td>Generic</td>
<td>No member responsibility</td>
</tr>
</tbody>
</table>
Medical Benefits

Medical Benefits apply when Covered Charges are incurred by a Covered Person for Preventive care services while the person is covered for these benefits under the Plan.

DEDUCTIBLE

Deductible Amount. This is an amount of Covered Charges for which no benefits will be paid. Before benefits can be paid in a Plan Year a Covered Person must meet the Deductible shown in the Schedule of Benefits.

Family Unit/Individual Deductible Accumulation. The family Deductible and out of pocket maximum is the maximum amount which must be incurred by the covered family members during a Plan Year.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual</td>
<td>No member responsibility</td>
<td>No member responsibility</td>
</tr>
<tr>
<td>Family</td>
<td>No member responsibility</td>
<td>No member responsibility</td>
</tr>
</tbody>
</table>

BENEFIT PAYMENT

Each Plan Year, benefits will be paid for the Covered Charges of a Covered Person that are in excess of the Deductible and any copayments. Payment will be made at the rate shown under reimbursement rate in the Schedule of Benefits. No benefits will be paid for any listed non-preventive health services not covered by the Plan.

OUT-OF-POCKET LIMIT

Covered Charges are payable at the percentages shown each Plan Year until the out-of-pocket limit shown in the Schedule of Benefits is reached.

<table>
<thead>
<tr>
<th></th>
<th>Network</th>
<th>Non-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual Maximum</td>
<td>No member responsibility</td>
<td>Unlimited</td>
</tr>
<tr>
<td>Family Maximum</td>
<td>No member responsibility</td>
<td>Unlimited</td>
</tr>
</tbody>
</table>

MAXIMUM BENEFIT AMOUNTS

The Maximum Benefit Amounts are shown in the Schedule of Benefits for various Preventive services. They are the total amount of benefits that will be paid under the Plan for all Covered Preventive Charges incurred by a Covered Person.

COVERED CHARGES

Covered Charges are the Usual and Customary Charges that are incurred for the following items of service and supply. These charges are subject to the non-preventive health benefit limits, exclusions and other provisions of this Plan. A charge is incurred on the date that the service or supply is performed or furnished.

Preventive Care. Charges for Preventive Care services.

Benefits mandated through the PPACA legislation include Preventive Care such as immunizations, screenings, and other services that are listed as recommended by the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Federal Centers for Disease Control (CDC).


Important Note: The Preventive Care services identified through this link are recommended services, not mandated services. It is up to the Provider of care to determine which services to provide;
Preventive and Wellness Services for Adults and Children - In compliance with section (2713) of the Patient Protection and Affordable Care Act, benefits are available for evidence-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force (USPSTF).

Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention with respect to the individual involved.

With respect to infants, children, and adolescents, evidence-informed Preventive Care and screenings as provided for in the comprehensive guidelines supported by the Health Resources and Services Administration.

A description of Preventive and Wellness Services can be found at: https://www.healthcare.gov/prevention

Women's Preventive Services - With respect to women, such additional Preventive Care and screenings as provided for in comprehensive guidelines supported by the Health Resources and Services Administration not otherwise addressed by the recommendations of the United States Preventive Service Task Force, which will be commonly known as HRSA's Women's Preventive Services Required Health Plan Coverage Guidelines. The HRSA has added the following eight categories of women's services to the list of mandatory preventive services:

1. Well-woman visits;
2. Gestational diabetes screening;
3. HPV DNA testing;
4. Sexually transmitted infection counseling;
5. HIV screening and counseling;
6. FDA-approved contraception methods and contraceptive counseling unless excluded by religious entity;
7. Breastfeeding support, supplies and counseling; and
8. Domestic violence screening and counseling

A description of Women's Preventive Services can be found at: http://www.hrsa.gov/womensguidelines/ or at https://www.healthcare.gov/prevention.

Smoking Cessation. Smoking Cessation treatment when determined medically necessary by the Plan Administrator and under the supervision of a physician. The length of treatment to be determined upon receipt of statement of medical necessity and to the extent required by the Patient Protection and Affordable Care Act (PPACA).

Sterilization All FDA approved charges related to sterilization procedures, to the extent required by the Patient Protection and Affordable Care Act (PPACA).

Contraceptives. The charges for all FDA approved contraceptives methods, in accordance with Health Resources and Services Administration (HRSA) guidelines, to the extent required by the Patient Protection and Affordable Care Act (PPACA) and not excluded by a religious entity.

Routine Patient Costs for Participation in an Approved Clinical Trial

Charges for any Medically Necessary services, for which benefits are provided by the Plan, when a Participant is participating in a phase I, II, III or IV clinical trial, conducted in relation to the prevention, detection or treatment of a life-threatening Disease or condition, provided:

a. The clinical trial is approved by:
   1. The Centers for Disease Control and Prevention of the U.S. Department of Health and Human Services;
   2. The National Institute of Health;
   3. The U.S. Food and Drug Administration;
4. The U.S. Department of Defense;
5. The U.S. Department of Veterans Affairs; or
6. In Institutional review board of an Institution that has an agreement with the Office for Human Research Protections of the U.S. Department of Health and Human Services; and

b. The research Institution conducting the Approved Clinical Trial and each health professional providing routine patient care through the Institution, agree to accept reimbursement at the applicable Allowable Expense, as payment in full for routine patient care provided in connection with the Approved Clinical Trial.

Coverage will not be provided for:

1. The cost of an Investigational new drug or device that is not approved for any indication by the U.S. Food and Drug Administration, including a drug or device that is the subject of the Approved Clinical Trial;
2. The cost of a service that is not a health care service, regardless of whether the service is required in connection with participation in an Approved Clinical Trial;
3. The cost of a service that is clearly inconsistent with widely accepted and established standards of care for a particular Diagnosis;
4. A cost associated with managing an Approved Clinical Trial;
5. The cost of a health care service that is specifically excluded by the Plan; or
6. Services that are part of the subject matter of the Approved Clinical Trial and that are customarily paid for by the research Institution conducting the Approved Clinical Trial.
Defined Terms

The following terms have special meanings and when used in this Plan will be capitalized.

**Active Employee** is an Employee who is on the regular payroll of the Employer and who has begun to perform the duties of his or her job with the Employer on a full-time.

**Actively-at-work** means that on the day that coverage under the plan would begin, an employee is not absent from work, or if he or she is absent from work, the absence is not related to the health of the employee.

**Approved Clinical Trial** is a phase I, II, III or IV trial that is Federally funded by specified Agencies (National Institutes of Health, CDCP, Agency for Health Care Research, Centers for Medicare and Medicaid Services (“CMS”), Dept. of Defense or Veterans Affairs, or a non-governmental entity identified by NIH guidelines) or is conducted under an Investigational new drug application reviewed by the FDA (if such application is required).

The Patient Protection and Affordable Care Act requires that if a "qualified individual" is in an "Approved Clinical Trial," the Plan cannot deny coverage for related services ("routine patient costs").

A "qualified individual" is someone who is eligible to participate in an "Approved Clinical Trial" and either the individual's doctor has concluded that participation is appropriate or the Participant provides medical and scientific information establishing that their participation is appropriate.

"Routine patient costs" include all items and services consistent with the coverage provided in the plan that is typically covered for a qualified individual who is not enrolled in a clinical trial. Routine patient costs do not include 1) the Investigational item, device or service itself; 2) items and services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the patient; and 3) a service that is clearly inconsistent with the widely accepted and established standards of care for a particular Diagnosis. Plans are not required to provide benefits for routine patient care services provided outside of the Plan’s Network area unless out-of-network benefits are otherwise provided under the Plan.

**Child** means in addition to the Employee's own blood descendant of the first degree or lawfully adopted Child, a Child placed with a covered Employee in anticipation of adoption, a covered Employee's Child who is an alternate recipient under a Qualified Medical Child Support Order as required by the Federal Omnibus Budget Reconciliation Act of 1993, any stepchild, an "eligible foster child," which is defined as an individual placed with the Employee by an authorized placement agency or by judgment, decree or other order of a court of competent jurisdiction or any other Child for whom the Employee has obtained legal guardianship.

**CHIP** refers to the Children’s Health Insurance Program or any provision or section thereof, which is herein specifically referred to; as such act, provision or section may be amended from time to time.

**CHIPRA** refers to the Children's Health Insurance Program Reauthorization Act of 2009 or any provision or section thereof, which is herein specifically referred to, as such act.

**A Clean Claim** is one that can be processed in accordance with the terms of this document without obtaining additional information from the service Provider or a third party. It is a claim which has no defect or impropriety. A Clean Claim does not include claims under investigation for fraud and abuse and Reasonableness, or fees under review for Usual and Customariness, or any other matter that may prevent the charge(s) from being covered expenses in accordance with the terms of this document.

**Filing a Clean Claim.** A Provider submits a Clean Claim by providing the required data elements on the standard claims forms, along with any attachments and additional elements or revisions to data elements, attachments and additional elements, of which the Provider has knowledge. The paper claim form or electronic file record must include all required data elements and must be complete, legible, and accurate. A claim will not be considered to be a Clean Claim if the Plan Participant has failed to submit required forms or additional information to the Plan as well.

**COBRA** means the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended.
**Covered Expense** means a Usual and Customary fee for a Reasonable, Preventive service, treatment or supply, meant to improve a condition or participant’s health, which is eligible for coverage in this Plan. Covered Expenses will be determined based upon all other Plan provisions.

**Covered Person** is an Employee or Dependent who is covered under this Plan.

**Employee** means a person who is an Active, regular Employee of the Employer, regularly scheduled to work for the Employer in an Employee/Employer relationship.

**Employer** is St. Francis Health Services, and it’s Affiliates.

**Enrollment Date** is the first day of coverage or, if there is a Waiting Period, the first day of the Waiting Period.

**ERISA** is the Employee Retirement Income Security Act of 1974, as amended.

**Essential Health Benefits** means, under section 1302(b) of the Patient Protection and Affordable Care Act, those health benefits under preventive and wellness services.

**Family Unit** is the covered Employee and the family members who are covered as Dependents under the Plan.

**FMLA** means the Family and Medical Leave Act of 1993, as amended.

**FMLA Leave** means a leave of absence, which the Company is required to extend to an Employee under the provisions of the FMLA.

**Foster Child** means an unmarried child under the limiting age shown in the Dependent Eligibility Section of this Plan for whom a covered Employee has assumed a legal obligation. All of the following conditions must be met: the child is being raised as the covered Employee’s; the child depends on the covered Employee for primary support; the child lives in the home of the covered Employee; and the covered Employee may legally claim the child as a federal income tax deduction.

A covered Foster Child is not a child temporarily living in the covered Employee’s home; one placed in the covered Employee’s home by a social service agency which retains control of the child; or whose natural parent(s) may exercise or share parental responsibility and control.

**Generic** drug means a Prescription Drug which has the equivalency of the brand name drug with the same use and metabolic disintegration. This Plan will consider as a Generic drug any Food and Drug Administration approved generic pharmaceutical dispensed according to the professional standards of a licensed pharmacist and clearly designated by the pharmacist as being generic.

**HIPAA** means the Health Insurance Portability and Accountability Act of 1996, as amended.

**In incurred** means that a covered expense is incurred on the date the service is rendered.

**Late Enrollee** means a Plan Participant who enrolls under the Plan other than during the first 31-day period in which the individual is eligible to enroll under the Plan or during a Special Enrollment Period.

**Legal Guardian** means a person recognized by a court of law as having the duty of taking care of the person and managing the property and rights of a minor child.

**Maximum Amount** and/or **Maximum Allowable Charge** means the benefit payable for a specific coverage item or benefit under the Plan. Maximum Allowable Charge(s) will be the lesser of:

- The Usual and Customary amount;
- The allowable charge specified under the terms of the Plan;
- The negotiated rate established in a contractual arrangement with a Provider; or
- The actual billed charges for the covered services.
The Plan will reimburse the actual charge billed if it is less than the Usual and Customary amount. The Plan has the discretionary authority to decide if a charge is Usual and Customary and for a Medically Necessary and Reasonable service.

The Maximum Allowable Charge will not include any identifiable billing mistakes including, but not limited to, up-coding, duplicate charges, and charges for services not performed.

Medicare is the Health Insurance for the Aged and Disabled program under Title XVIII of the Social Security Act, as amended and as may be amended, entitled Health Insurance for the Aged Act, and which Includes Part A - Hospital Insurance Benefits for the aged and Part B - Supplementary Medical Insurance Benefits for the Aged.

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

A Network Provider is a provider that is a member of the preferred provider network. The member list is subject to change.

A Non-Network Provider is a provider that is not a member of the preferred provider network.

An Open Enrollment Period is a period during which an individual may apply for or adjust coverage under the benefit plan(s) of the company.

A Participant is a person directly involved in the regular business of and compensated for services by the company, who is regularly scheduled to work a normal work week, as defined by the Employer.

Pharmacy means a licensed establishment where covered Prescription Drugs are filled and dispensed by a pharmacist licensed under the laws of the state where he or she practices.

Physician means a Doctor of Medicine (M.D.), Doctor of Osteopathy (D.O.), Doctor of Podiatry (D.P.M.), Doctor of Chiropractic (D.C.), Audiologist, Certified Nurse Anesthetist, Licensed Professional Counselor, Licensed Professional Physical Therapist, Master of Social Work (M.S.W.), Midwife, Occupational Therapist, Doctor of Dental Surgery (D.D.S.), Physiotherapist, Psychiatrist, Psychologist (Ph.D.), Speech Language Pathologist and any other practitioner of the healing arts who is licensed and regulated by a state or federal agency and is acting within the scope of his or her license.

Plan means St. Francis Health Services Preventive Medical Services Plan, which is a benefits plan for certain Employees of St. Francis Health Services and is described in this document.

The Plan Administrator is the person, group, or organization responsible for the day-to-day functions and management of the plan. The plan administrator may employ persons or firms to process claims and perform other plan-connected services. The plan administrator is the company that is the named fiduciary.

The term Plan Document whenever used herein shall mean the document held by the company, which describes the terms and conditions of the benefits of the plan.

Plan Participant is any Employee or Dependent who is covered under this Plan.

Plan Year is the 12-month period beginning on either the effective date of the Plan or on the day following the end of the first Plan Year which is a short Plan Year.

PPACA means Patient Protection and Affordable Care Act.

Prescription Drug means any of the following: a Food and Drug Administration-approved drug or medicine which, under federal law, is required to bear the legend: "Caution: federal law prohibits dispensing without prescription"; injectable insulin; hypodermic needles or syringes, but only when dispensed upon a written prescription of a licensed Physician. Such drug must be Medically Necessary in the treatment of a Sickness or Injury.
Preventive Benefits are healthcare services that are provided to help prevent or detect an illness or disease.

This Plan intends to comply with the Patient Protection and Affordable Care Act's (PPACA) requirement to offer in-Network coverage for certain preventive services without cost-sharing. To comply with PPACA, and in accordance with the recommendations and guidelines, the Plan will provide in-Network coverage for:

1. Evidence-based items or services rated A or B in the United States Preventive Services Task Force recommendations;
2. Recommendations of the Advisory Committee on Immunization Practices adopted by the Director of the Centers for Disease Control and Prevention;
3. Comprehensive guidelines for infants, children, and adolescents supported by the Health Resources and Services Administration (HRSA); and
4. Comprehensive guidelines for women supported by the Health Resources and Services Administration (HRSA).

Copies of the recommendations and guidelines may be found here: http://www.uspreventiveservicestaskforce.org/uspsf/uspsabrecs.htm or at https://www.healthcare.gov/prevention. For more information, you may contact the Plan Administrator / Employer at (952)896-1200 or service@healthez.com.

The term Special Enrollee means an employee or dependent that is entitled to, is qualified for, and who requests special enrollment under the plan within 30 days of losing other health coverage or who is added to the plan as a result of marriage, birth, placement for adoption, or is a newly adopted child under the age of 18.

The term Spouse means a person who is legally married to the participant.

Usual and Customary (U&C) means covered expenses which are identified by the Plan Administrator, taking into consideration the fee(s) which the Provider most frequently charges the majority of patients for the service or supply, the cost to the Provider for providing the services, the prevailing range of fees charged in the same "area" by Providers of similar training and experience for the service or supply, and the Medicare reimbursement rates. The term(s) "same geographic locale" and/or "area" shall be defined as a metropolitan area, county, or such greater area as is necessary to obtain a representative cross-section of Providers, persons or organizations rendering such treatment, services, or supplies for which a specific charge is made. To be Usual and Customary, fee(s) must be in compliance with generally accepted billing practices for unbundling or multiple procedures.

The term "Usual" refers to the amount of a charge made for medical services, care, or supplies, to the extent that the charge does not exceed the common level of charges made by other medical professionals with similar credentials, or health care facilities, pharmacies, or equipment suppliers of similar standing, which are located in the same geographic locale in which the charge is incurred.

The term "Customary" refers to the form and substance of a service, supply, or treatment provided in accordance with generally accepted standards of medical practice to one individual, which is appropriate for the care or treatment of the same sex, comparable age and who receive such services or supplies within the same geographic locale.

The term "Usual and Customary" does not necessarily mean the actual charge made nor the specific service or supply furnished to a Plan Participant by a Provider of services or supplies, such as a physician, therapist, nurse, hospital, or pharmacist. The Plan Administrator will determine what the Usual and Customary charge is, for any procedure, service, or supply, and whether a specific procedure, service or supply is Usual and Customary.

Usual and Customary charges may, at the Plan Administrator's discretion, alternatively be determined and established by the Plan using normative data such as, but not limited to, Medicare cost to charge ratios, average wholesale price (AWP) for prescriptions and/or manufacturer's retail pricing (MRP) for supplies and devices.
General Plan Exclusions

Covered expenses do not include and no benefits are payable for the following:

1. Before or after coverage. The plan does not cover expenses incurred before coverage began or after coverage terminated. An expense for a service is incurred on the date the service is furnished.

2. Communications and Accessibility Services. Provider charges for interpretation, translation, accessibility or special accommodations. Devices and computers to assist in communication and speech. Professional sign language or foreign language interpreter services in a physician’s office.

3. Excess charges. Charges that are not payable under the Plan due to application of any Plan maximum or limit or because the charges are in excess of the Usual and Customary amount, or are for services not deemed to be Reasonable or Medically Necessary, based upon the Plan Administrator’s determination as set forth by and within the terms of this document.

4. Family Member. Professional services that are performed by a person who is related to the Participant as a spouse, parent, Child, brother or sister, whether the relationship exists by virtue of “blood” or “in law”.

5. Government. That the Participant obtains, but which is paid, may be paid, is provided or could be provided for at no cost to the Participant through any program or agency, in accordance with the laws or regulations of any government, or where care is provided at government expense, unless there is a legal obligation for the Participant to pay for such treatment or service in the absence of coverage. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare.

6. Government-Operated Facilities. That are furnished to the Participant in any veteran’s Hospital, military Hospital, Institution or facility operated by the United States government or by any state government or any agency or instrumentality of such governments; and That can be paid for by any government agency, even if the patient waives his rights to those services or supplies. NOTE: This exclusion does not apply to treatment of non-service related disabilities or for inpatient care provided in a military or other Federal government Hospital to Dependents of active duty armed service personnel or armed service retirees and their Dependents. This exclusion does not apply where otherwise prohibited by law.

7. Illegal Drugs or Medications. That are services, supplies, care or treatment to a Participant for Injury or Sickness resulting from that Participant’s voluntary taking of or being under the influence of any controlled substance, Drug, hallucinogen or narcotic not administered on the advice of a Physician. Expenses will be covered for Injured Participants other than the person using controlled substances and expenses will be covered for Substance Abuse treatment as specified in this Plan. This exclusion does not apply (a) if the Injury resulted from being the victim of an act of domestic violence, or (b) resulted from a medical condition (including both physical and mental health conditions).

8. Incurred by Other Persons. For expenses actually incurred by other persons.

9. Illness or Injury. Services for the treatment of an illness or injury shall not be covered by the Plan.

10. Investigatory and experimental. Investigatory and experimental treatment, services, and supplies, unless provided for herein.

11. Medicare. Services that are provided, or which would have been provided had the Participant enrolled, applied for, or maintained eligibility for such care and service benefits, under Title XVIII of the Federal Social Security Act of 1965 (Medicare), including any amendments thereto, or under any Federal law or regulation, except as provided in the section entitled “Medicare.”

12. No obligation to pay. Charges that the participant is not legally required to pay for or charges which would not have been made if this coverage has not existed.
(13) **Non-Prescription Drugs.** Drugs that are for use outside of a Hospital or other Inpatient facility that can be purchased over-the-counter and without a Physician’s written prescription. Drugs for which there is a non-prescription equivalent available. This does not apply to the extent the non-prescription Drug must be covered under Preventive Care, subject to the Patient Protection and Affordable Care Act.

(14) **Not Acceptable.** Services that are not accepted as standard practice by the AMA, ADA, or the Food and Drug Administration.

(15) **Not Specified As Covered.** Services that are not specified as covered under any provision of this Plan.

(16) **Non-network charges** that are in excess of the reasonable and customary rates for the services as determined by the plan.

(17) **Non-preventive services.** Services that are not preventive services will not be covered by the Plan.

(18) **Other than healthcare provider.** Treatment of services provided by anyone other than a healthcare provider as defined herein unless specifically stated in the Plan.

(19) **Postage, Shipping, Handling Charges, Etc.** That are for any postage, shipping or handling charges which may occur in the transmittal of information to the Third Party Administrator; including interest or financing charges.

(20) **Prohibited by Law.** That are to the extent that payment under this Plan is prohibited by law.

(21) **Treatment of services** provided by anyone other than a healthcare provider as a defined herein unless specifically stated in the Plan.

(22) **Unreasonable.** That are not “Reasonable,” and are required to treat illness or Injuries arising from and due to a Provider’s error, wherein such illness, injury, infection or complication is not reasonably expected to occur. This exclusion will apply to expenses directly or indirectly resulting from circumstances that, in the opinion of the Plan Administrator in its sole discretion, gave rise to the expense are not generally foreseeable or expected amongst professionals practicing the same or similar type(s) of medicine as the treating Provider whose error caused the loss(es).
Prescription Drug Benefits

Pharmacy Drug Charge

Participating pharmacies have contracted with the Plan to charge Covered Persons reduced fees for covered Prescription Drugs.

Covered Prescription Drugs

(1) All preventive drugs prescribed by a Physician that require a prescription either by federal or state law and excludes any drugs stated as not covered under this Plan.

(2) Limited to preventive drugs specifically outlined under PPACA excluding contraceptives

Limits to This Benefit

This benefit applies only when a Covered Person incurs a covered Prescription Drug charge. The covered drug charge for any one prescription will be limited to:

(1) Refills only up to the number of times specified by a Physician; or,

(2) Refills up to one year from the date of order by a Physician.

Expenses Not Covered

This benefit will not cover a charge for any of the following:

(1) Administration. Any charge for the administration of a covered Prescription Drug.

(2) Consumed on premises. Any drug or medicine that is consumed or administered at the place where it is dispensed.

(3) Devices. Devices of any type, even though such devices may require a prescription.

(4) Experimental. Experimental drugs and medicines, even though a charge is made to the Covered Person.

(5) FDA. Any drug not approved by the Food and Drug Administration.

(6) No charge. A charge for Prescription Drugs which may be properly received without charge under local, state or federal programs.

(7) Non-legend drugs. A charge for FDA-approved drugs that are prescribed for non-FDA-approved uses.

(8) No prescription. A drug or medicine that can legally be bought without a written prescription.

(9) Refills. Any refill that is requested more than one year after the prescription was written or any refill that is more than the number of refills ordered by the Physician.

(10) Over-the-counter Items and Medications. Over-the-counter items and medications, except as specifically listed as a covered benefit herein or in the Schedule of Benefits. For purposes of the Evidence of Coverage Over-the-Counter is defined as any item, supply or medication which can be purchased or obtained from a vendor or without a prescription.
Coordination of Benefits

When a Participant is covered by this Plan and another plan, or the Employee's Spouse is covered by this Plan and by another plan or the couple's Covered children are covered under two or more plans, this Plan will always pay as primary and will not coordinate benefits with any other Plan.
How to Submit a Claim

Benefits under this Plan shall be paid only if the Plan Administrator decides in its discretion that a Covered Person is entitled to them.

When a Covered Person has a Claim to submit for payment that person must:

1. Obtain a Claim form from the Personnel Office or the Plan Administrator;
2. Complete the Employee portion of the form. ALL QUESTIONS MUST BE ANSWERED;
3. Have the Physician complete the provider's portion of the form;
4. For Plan reimbursements, attach bills for services rendered, ALL BILLS MUST SHOW:
   - Name of Plan
   - Employee's name
   - Name of patient
   - Name, address, telephone number of the provider of care
   - Diagnosis
   - Type of services rendered, with diagnosis and/or procedure codes
   - Date of services
   - Charges; and,
5. Send the above to the Claims Administrator at this address:
   
   HealthEZ
   P.O. Box 398220
   Minneapolis, Minnesota 55439-8820

WHEN CLAIMS SHOULD BE FILED

Claims should be filed with the Claims Administrator within 90 days of the date charges for the services were incurred. Benefits are based on the Plan's provisions at the time the charges were incurred. Claims filed later than that date may be declined or reduced unless:

(a) it's not reasonably possible to submit the claim in that time; and
(b) the claim is submitted within one year from the date incurred. This one year period will not apply when the person is not legally capable of submitting the claim.

The Claims Administrator will determine if enough information has been submitted to enable proper consideration of the claim. If not, more information may be requested from the claimant. The Plan reserves the right to have a Plan Participant seek a second medical opinion.
CLAIMS PROCEDURE

Following is a description of how the Plan processes Claims for benefits. A Claim is defined as any request for a Plan benefit, made by a claimant or by a representative of a claimant, which complies with the Plan’s reasonable procedure for making benefit Claims. The times listed are maximum times only. A period of time begins at the time the Claim is filed. Decisions will be made within a reasonable period of time appropriate to the circumstances. "Days" means calendar days.

Post-Service Claim

A Post-Service Claim means any Claim for a Plan benefit that is a request for payment under the Plan for covered medical services already received by the claimant.

<table>
<thead>
<tr>
<th>In the case of a Post-Service Claim, the following timetable applies:</th>
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<tbody>
<tr>
<td>Notification to claimant of benefit determination</td>
<td>30 days</td>
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<tr>
<td>Extension due to matters beyond the control of the Plan</td>
<td>15 days</td>
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<tr>
<td>Extension due to insufficient information on the Claim</td>
<td>15 days</td>
</tr>
<tr>
<td>Response by claimant following notice of insufficient information</td>
<td>45 days</td>
</tr>
<tr>
<td>Review of adverse benefit determination</td>
<td>30 days per benefit appeal</td>
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Notice to claimant of adverse benefit determinations

The Plan Administrator shall provide a Participant with notification, with respect to pre-service urgent care claims, by telephone, facsimile or similar method, and with respect to all other types of claims, in writing or electronically, of a Plan’s Adverse Benefit Determination on review, setting forth:

1. Information sufficient to allow the Participant to identify the claim involved (including date of service, the healthcare Provider, the claim amount, if applicable, and a statement describing the availability, upon request, of the Diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning);
2. A reference to the specific portion(s) of the plan provisions upon which a denial is based;
3. Specific reason(s) for a denial, including the denial code and its corresponding meaning, and a description of the Plan’s standard, if any, that was used in denying the claim, and a discussion of the decision;
4. A description of any additional information necessary for the Participant to perfect the claim and an explanation of why such information is necessary;
5. A description of available internal appeals and external review processes, including information regarding how to initiate an appeal;
6. A description of the Plan’s review procedures and the time limits applicable to the procedures. This description will include information on how to initiate the appeal and a statement of the Participant’s right to bring a civil action under section 502(a) of ERISA following an Adverse Benefit Determination on final review;
7. A statement that the Participant is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Participant’s claim for benefits;
8. The identity of any medical or vocational experts consulted in connection with a claim, even if the Plan did not rely upon their advice (or a statement that the identity of the expert will be provided, upon request);
9. Any rule, guideline, protocol or similar criterion that was relied upon, considered, or generated in making the determination will be provided free of charge. If this is not practical, a statement will be included that such a rule, guideline, protocol or similar criterion was relied upon in making the determination and a copy will be provided to the Participant, free of charge, upon request;
10. In the case of denials based upon a medical judgment (such as whether the treatment is Medically Necessary or Experimental), either an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to the Participant’s medical circumstances, will be provided. If this is not practical, a statement will be included that such explanation will be provided to the Participant, free of charge, upon request; and
11. The following statement: "You and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your state insurance regulatory agency."

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Appeals

When a claimant receives an adverse benefit determination, the claimant has 180 days following receipt of the notification in which to appeal the decision. A claimant may submit written comments, documents, records, and other information relating to the Claim. If the claimant so requests, he or she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the Claim.

The period of time within which a benefit determination on review is required to be made shall begin at the time an appeal is filed in accordance with the procedures of the Plan. This timing is without regard to whether all the necessary information accompanies the filing.

A document, record, or other information shall be considered relevant to a Claim if it:

1. was relied upon in making the benefit determination;

2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;

3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with Plan documents and Plan provisions have been applied consistently with respect to all claimants; or

4. constituted a statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit.

The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the Claim, without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial adverse benefit determination and will be conducted by a fiduciary of the Plan who is neither the individual who made the adverse determination nor a subordinate of that individual.

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is Experimental, Investigational, or not Medically Necessary or appropriate, the fiduciary shall consult with a health care professional who was not involved in the original benefit determination. This health care professional will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the initial determination will be identified.

External Review Process

The Federal external review process does not apply to a denial, reduction, termination, or a failure to provide payment for a benefit based on a determination that a participant or beneficiary fails to meet the requirements for eligibility under the terms of a group health plan.

The Federal external review process applies only to:

1. An Adverse Benefit Determination (including a Final Internal Adverse Benefit Determination) by a plan or issuer that involves medical judgment (including, but not limited to, those based on the plan's or issuer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or its determination that a treatment is Experimental or Investigational), as determined by the external reviewer; and

2. A rescission of coverage (whether or not the rescission has any effect on any particular benefit at that time).
Standard external review

Standard external review is external review that is not considered expedited (as described in the "expedited external review" paragraph in this section).

(1) Request for external review. The Plan will allow a claimant to file a request for an external review with the Plan if the request is filed within 4 months after the date of receipt of a notice of an Adverse Benefit Determination or Final Internal Adverse Benefit Determination. If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date would fall on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

(2) Preliminary review. Within 5 business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether:
   a. The claimant is or was covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, was covered under the Plan at the time the health care item or service was provided;
   b. The Adverse Benefit Determination or the final Adverse Benefit Determination does not relate to the claimant's failure to meet the requirements for eligibility under the terms of the Plan (e.g., worker classification or similar determination);
   c. The claimant has exhausted the Plan's internal appeal process unless the claimant is not required to exhaust the internal appeals process under the interim final regulations;
   d. The claimant has provided all the information and forms required to process an external review. Within one (1) business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant. If the request is complete but not eligible for external review, such notification will include the reasons for its ineligibility and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)). If the request is not complete, such notification will describe the information or materials needed to make the request complete and the Plan will allow a claimant to perfect the request for external review with the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(3) Referral to Independent Review Organization. The Plan will assign an independent review organization (IRO) that is accredited by URAC or by a similar nationally-recognized accrediting organization to conduct the external review. Moreover, the Plan will take action against bias and to ensure independence. Accordingly, the Plan will contract with (or direct the Claims Processor to contract with, on its behalf) at least 3 IROs for assignments under the Plan and rotate claims assignments among them (or incorporate other independent unbiased method for selection of IROs, such as random selection). In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

(4) Reversal of Plan's decision. Upon receipt of a notice of a final external review decision reversing the Adverse Benefit Determination or Final Internal Adverse Benefit Determination, the Plan will provide coverage or payment for the claim without delay, regardless of whether the plan intends to seek judicial review of the external review decision and unless or until there is a judicial decision otherwise.

Expedited external review

(1) Request for expedited external review. The Plan will allow a claimant to make a request for an expedited external review with the Plan at the time the claimant receives:
   a. An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of a standard internal appeal under the interim final regulations would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has filed a request for an expedited internal appeal; or
   b. A Final Internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the Final Internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency Services, but has not been discharged from a facility.
(2) **Preliminary review.** Immediately upon receipt of the request for expedited external review, the Plan will determine whether the request meets the reviewability requirements set forth above for standard external review. The Plan will immediately send a notice that meets the requirements set forth above for standard external review to the claimant of its eligibility determination.

(3) **Referral to Independent Review Organization.** Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO pursuant to the requirements set forth above for standard review. The Plan will provide or transmit all necessary documents and information considered in making the Adverse Benefit Determination or Final Internal Adverse Benefit Determination to the assigned IRO electronically or by telephone or facsimile or any other available expeditious method. The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, will consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO will review the claim de novo and is not bound by any decisions or conclusions reached during the Plan’s internal claims and appeals process.

(4) **Notice of final external review decision.** The Plan’s (or Claim Processor’s) contract with the assigned IRO will require the IRO to provide notice of the final external review decision, in accordance with the requirements set forth above, as expeditiously as the claimant’s medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO will provide written confirmation of the decision to the claimant and the Plan.

**Recovery of Payments**

Occasionally, benefits are paid more than once, are paid based upon improper billing or a misstatement in a proof of loss or enrollment information, are not paid according to the Plan’s terms, conditions, limitations or exclusions, or should otherwise not have been paid by the Plan. As such this Plan may pay benefits that are later found to be greater than the Maximum Allowable Charge. In this case, this Plan may recover the amount of the overpayment from the source to which it was paid, primary payers, or from the party on whose behalf the charge(s) were paid. As such, whenever the Plan pays benefits exceeding the amount of benefits payable under the terms of the Plan, the Plan Administrator has the right to recover any such erroneous payment directly from the person or entity who received such payment and/or from other payers and/or the Plan Participant or dependent on whose behalf such payment was made.

A Plan Participant, Dependent, Provider, another benefit plan, insurer, or any other person or entity who receives a payment exceeding the amount of benefits payable under the terms of the Plan or on whose behalf such payment was made, shall return or refund the amount of such erroneous payment to the Plan within 30 days of discovery or demand. The Plan Administrator shall have no obligation to secure payment for the expense for which the erroneous payment was made or to which it was applied.

The person or entity receiving an erroneous payment may not apply such payment to another expense. The Plan Administrator shall have the sole discretion to choose who will repay the Plan for an erroneous payment and whether such payment shall be reimbursed in a lump sum. When a Plan Participant or other entity does not comply with the provisions of this section, the Plan Administrator shall have the authority, in its sole discretion, to deny payment of any claims for benefits by the Plan Participant and to deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Plan by the amount due as reimbursement to the Plan. The Plan Administrator may also, in its sole discretion, deny or reduce future benefits (including future benefits for other injuries or illnesses) under any other group benefits plan maintained by the Plan Sponsor. The reductions will equal the amount of the required reimbursement.

Providers and any other person or entity accepting payment from the Plan or to whom a right to benefits has been assigned, in consideration of services rendered, payments and/or rights, agrees to be bound by the terms of this Plan and agree to submit claims for reimbursement in strict accordance with their State’s health care practice acts, ICD-9 or CPT standards, Medicare guidelines, HCPCS standards, or other standards approved by the Plan Administrator or insurer. Any payments made on claims for reimbursement not in accordance with the above provisions shall be repaid to the Plan within 30 days of discovery or demand or incur prejudgment interest of 1.5% per month. If the Plan must bring an action against a Plan Participant, Provider or other person or entity to enforce the provisions of this section, then that Plan Participant, Provider or other person or entity agrees to pay the Plan’s attorneys’ fees and costs, regardless of the action’s outcome.
Further, Plan Participants and/or their dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (Plan Participants) shall assign or be deemed to have assigned to the Plan their right to recover said payments made by the Plan, from any other party and/or recovery for which the Plan Participant(s) are entitled, for or in relation to facility-acquired condition(s), Provider error(s), or damages arising from another party's act or omission for which the Plan has not already been refunded.

The Plan reserves the right to deduct from any benefits properly payable under this Plan the amount of any payment which has been made:

1. In error;
2. Pursuant to a misstatement contained in a proof of loss or a fraudulent act;
3. Pursuant to a misstatement made to obtain coverage under this Plan within two years after the date such coverage commences;
4. With respect to an ineligible person;
5. Pursuant to a claim for which benefits are recoverable under any policy or act of law providing for coverage for occupational injury or disease to the extent that such benefits are recovered. This provision (6) shall not be deemed to require the Plan to pay benefits under this Plan in any such instance.

The deduction may be made against any claim for benefits under this Plan by a Plan Participant or by any of his Covered Dependents if such payment is made with respect to the Plan Participant or any person covered or asserting coverage as a Dependent of the Plan Participant.

If the Plan seeks to recoup funds from a Provider, due to a claim being made in error, a claim being fraudulent on the part of the Provider, and/or the claim that is the result of the Provider's misstatement, said Provider shall, as part of its assignment to benefits from the Plan, abstain from billing the plan participant for any outstanding amount(s).

Facility of payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any Other Plans, the Plan Administrator may, in its sole discretion, pay any organizations making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of recovery. In accordance with the Recovery of Payments provision, whenever payments have been made by this Plan with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this Article, the Plan shall have the right to recover such payments, to the extent of such excess, from any one or more of the following as this Plan shall determine: any person to or with respect to whom such payments were made, or such person’s legal representative, any insurance companies, or any other individuals or organizations which the Plan determines are responsible for payment of such Allowable Expenses, and any future benefits payable to the Participant or his or her Dependents. Please see the Recovery of Payments provision above for more details.

Exception to Medicaid. In accordance with ERISA, the Plan shall not take into consideration the fact that an individual is eligible for or is provided medical assistance through Medicaid when enrolling an individual in the Plan or making a determination about the payments for benefits received by a Covered Person under the Plan.
Continuation Coverage Rights Under COBRA

Under federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), certain Employees and their families covered under St. Francis Health Services, Preventive Medical Services Plan (the Plan) will be entitled to the opportunity to elect a temporary extension of health coverage (called "COBRA continuation coverage") where coverage under the Plan would otherwise end. This notice is intended to inform Plan Participants and beneficiaries, in summary fashion, of their rights and obligations under the continuation coverage provisions of COBRA, as amended and reflected in final and proposed regulations published by the Department of the Treasury. This notice is intended to reflect the law and does not grant or take away any rights under the law.

What is COBRA continuation coverage? COBRA continuation coverage is the temporary extension of group health plan coverage that must be offered to certain Plan Participants and their eligible family members (called "Qualified Beneficiaries") at group rates. The right to COBRA continuation coverage is triggered by the occurrence of a life event that results in the loss of coverage under the terms of the Plan (the "Qualifying Event"). The coverage must be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage must be identical to the coverage provided to similarly situated active employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

Who can become a Qualified Beneficiary? In general, a Qualified Beneficiary can be:

(1) Any individual who, on the day before a Qualifying Event, is covered under a Plan by virtue of being on that day either a covered Employee, the Spouse of a covered Employee, or a Dependent child of a covered Employee. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

(2) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, and any individual who is covered by the Plan as an alternate recipient under a qualified medical support order. If, however, an individual who otherwise qualifies as a Qualified Beneficiary is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the individual will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that individual experiences a Qualifying Event.

The term "covered Employee" includes not only common-law employees (whether part-time, ¾ time, or full-time) but also any individual who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed individuals, independent contractor, or corporate director). However, this provision does not establish eligibility of these individuals. Eligibility for Plan Coverage shall be determined in accordance with Plan Eligibility provisions.

An individual is not a Qualified Beneficiary if the individual's status as a covered Employee is attributable to a period in which the individual was a nonresident alien who received from the individual's Employer no earned income that constituted income from sources within the United States. If, on account of the preceding reason, an individual is not a Qualified Beneficiary, then a Spouse or Dependent child of the individual will also not be considered a Qualified Beneficiary by virtue of the relationship to the Individual. A domestic partner is not a Qualified Beneficiary.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.
What is a Qualifying Event? A Qualifying Event is any of the following if the Plan provided that the Plan participant would lose coverage (i.e.: cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

1. The death of a covered Employee;
2. The termination (other than by reason of the Employee's gross misconduct), or reduction of hours, of a covered Employee's employment;
3. The divorce or legal separation of a covered Employee from the Employee's Spouse. If the Employee reduces or eliminates the Employee's Spouse's Plan coverage in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the divorce or legal separation may be considered a Qualifying Event even though the Spouse's coverage was reduced or eliminated before the divorce or legal separation;
4. A covered Employee's enrollment in any part of the Medicare program; or,
5. A Dependent child's ceasing to satisfy the Plan's requirements for a Dependent child (for example, attainment of the maximum age for dependency under the Plan).

If the Qualifying Event causes the covered Employee, or the covered Spouse or a Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of COBRA are also met. For example, any increase in contribution that must be paid by a covered Employee, or the Spouse, or a Dependent child of the covered Employee, for coverage under the Plan that results from the occurrence of one of the events listed above is a loss of coverage.

The taking of leave under the Family and Medical Leave Act of 1993 ("FMLA") does not constitute a Qualifying Event. A Qualifying Event will occur, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the employee portion of premiums for coverage under the Plan during the FMLA leave.

What factors should be considered when determining to elect COBRA continuation coverage? You should take into account that a failure to continue your group health coverage will affect your rights under federal law. If you do not elect COBRA continuation coverage and pay the appropriate premiums for the maximum time available to you, you will lose the right to convert to an individual health insurance policy. Finally, you should take into account that you have special enrollment rights under federal law (HIPAA). You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days after Plan coverage ends due to a Qualifying Event listed above. You will also have the same special right at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

What is the procedure for obtaining COBRA continuation coverage? The Plan has conditioned the availability of COBRA continuation coverage upon the timely election of such coverage. An election is timely if it is made during the election period.

What is the election period and how long must it last? The election period is the time period within which the Qualified Beneficiary must elect COBRA continuation coverage under the Plan. The election period must begin no later than the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event or the date notice is provided to the Qualified Beneficiary of her or his right to elect COBRA continuation coverage. If coverage is not elected within the 60 day period, all rights to elect COBRA continuation coverage are forfeited.
Note: If a covered employee who has been terminated or experienced a reduction of hours qualifies for a trade readjustment allowance or alternative trade adjustment assistance under a federal law called the Trade Act of 2002, and the employee and his or her covered dependents have not elected COBRA coverage within the normal election period, a second opportunity to elect COBRA coverage will be made available for themselves and certain family members, but only within a limited period of 60 days or less and only during the six months immediately after their group health plan coverage ended. Any person who qualifies or thinks that he and/or his family members may qualify for assistance under this special provision should contact the Plan Administrator for further information.

The Trade Act of 2002 also created a new tax credit for certain TAA-eligible individuals and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 85% of premiums paid for qualified health insurance, including continuation coverage. If you have questions about these new tax provisions, you may call the Health Coverage Tax Credit Consumer Contact Center toll-free at 1-866-628-4282. TTD/TTY callers may call toll-free at 1-866-628-4282. More information about the Trade Act is also available at www.doleta.gov/tradeact.

Is a covered Employee or Qualified Beneficiary responsible for informing the Plan Administrator of the occurrence of a Qualifying Event? The Plan will offer COBRA continuation coverage to Qualified Beneficiaries only after the Plan Administrator or its designee has been timely notified that a Qualifying Event has occurred. The employer (if the employer is not the Plan Administrator) will notify the Plan Administrator of the Qualifying Event within 30 days following the date coverage ends when the Qualifying Event is:

1. the end of employment or reduction of hours of employment;
2. death of the employee;
3. commencement of a proceeding in bankruptcy with respect to the employer; or
4. enrollment of the employee in any part of Medicare.

IMPORTANT:

For the other Qualifying Events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you or someone on your behalf must notify the Plan Administrator or its designee in writing within 60 days after the Qualifying Event occurs, using the procedures specified below. If these procedures are not followed or if the notice is not provided in writing to the Plan Administrator or its designee during the 60-day notice period, any spouse or dependent child who loses coverage will not be offered the option to elect continuation coverage. You must send this notice to the Plan Sponsor.
NOTICE PROCEDURES:

Any notice that you provide must be **in writing**. Oral notice, including notice by telephone, is not acceptable. You must mail, fax or hand-deliver your notice to the person, department or firm listed below, at the following address:

<table>
<thead>
<tr>
<th>HealthEZ</th>
</tr>
</thead>
<tbody>
<tr>
<td>7201 West 78th St. STE 100</td>
</tr>
<tr>
<td>Bloomington, MN 55439</td>
</tr>
</tbody>
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If mailed, your notice must be postmarked no later than the last day of the required notice period. Any notice you provide must state:

- the name of the plan or plans under which you lost or are losing coverage,
- the name and address of the employee covered under the plan,
- the name(s) and address(es) of the Qualified Beneficiary(ies), and
- the Qualifying Event and the date it happened.

If the Qualifying Event is a *divorce or legal separation*, your notice must include a copy of the divorce decree or the legal separation agreement.

Be aware that there are other notice requirements in other contexts, for example, in order to qualify for a disability extension.

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Once the Plan Administrator or its designee receives *timely 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 for their spouses, and parents may elect COBRA continuation coverage on behalf of their children. For each Qualified Beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that plan coverage would otherwise have been lost. If you or your spouse or dependent children do not elect continuation coverage within the 60-day election period described above, the right to elect continuation coverage will be lost.

**Is a waiver before the end of the election period effective to end a Qualified Beneficiary’s election rights?** If, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. However, if a waiver is later revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). Waivers and revocations of waivers are considered made on the date they are sent to the Plan Administrator or its designee, as applicable.

**Is COBRA coverage available if a Qualified Beneficiary has other group health plan coverage or Medicare?** Qualified beneficiaries who are entitled to elect COBRA continuation coverage may do so even if they are covered under another group health plan or are entitled to Medicare benefits on or before the date on which COBRA is elected. However, a Qualified Beneficiary’s COBRA coverage will terminate automatically if, after electing COBRA, he or she becomes entitled to Medicare or becomes covered under other group health plan coverage (but only after any applicable preexisting condition exclusions of that other plan have been exhausted or satisfied).

**When may a Qualified Beneficiary’s COBRA continuation coverage be terminated?** During the election period, a Qualified Beneficiary may waive COBRA continuation coverage. Except for an interruption of coverage in connection with a waiver, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

1. The last day of the applicable maximum coverage period;
2. The first day for which Timely Payment is not made to the Plan with respect to the Qualified Beneficiary;
3. The date upon which the Employer ceases to provide any group health plan (including a successor plan) to any employee;

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(4) The date, after the date of the election, that the Qualified Beneficiary first enrolls in the Medicare program (either part A or part B, whichever occurs earlier); or,

(5) In the case of a Qualified Beneficiary entitled to a disability extension, the later of:

(a) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(b) the end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

The Plan can terminate for cause the coverage of a Qualified Beneficiary on the same basis that the Plan terminates for cause the coverage of similarly situated non-COBRA beneficiaries, for example, for the submission of a fraudulent claim.

In the case of an individual who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the individual’s relationship to a Qualified Beneficiary, if the Plan’s obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the individual who is not a Qualified Beneficiary.

What are the maximum coverage periods for COBRA continuation coverage? The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below:

(1) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is not a disability extension and 29 months after the Qualifying Event if there is a disability extension;

(2) In the case of a covered Employee’s enrollment in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(a) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(b) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee’s termination of employment or reduction of hours of employment;

(3) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption; or

(4) In the case of any other Qualifying Event than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

Under what circumstances can the maximum coverage period be expanded? If a Qualifying Event that gives rise to an 18-month or 29-month maximum coverage period is followed, within that 18-month or 29-month period, by a second Qualifying Event that gives rise to a 36-months maximum coverage period, the original period is expanded to 36 months, but only for individuals who are Qualified Beneficiaries at the time of and with respect to both Qualifying Events. In no circumstance can the COBRA maximum coverage period be expanded to more than 36 months after the date of the first Qualifying Event. The Plan Administrator must be notified of the second Qualifying Event within 60 days of the second Qualifying Event. This notice must be sent to the Plan Sponsor in accordance with the procedures above.
How does a Qualified Beneficiary become entitled to a disability extension? A disability extension will be granted if an individual (whether or not the covered Employee) who is a Qualified Beneficiary in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, is determined under Title II or XVI of the Social Security Act to have been disabled at any time during the first 60 days of COBRA continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage. This notice should be sent to the Plan Sponsor in accordance with the procedures above.

Does the Plan require payment for COBRA continuation coverage? For any period of COBRA continuation coverage under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. Qualified beneficiaries will pay up to 102% of the applicable premium and up to 150% of the applicable premium for any expanded period of COBRA continuation coverage covering a disabled Qualified Beneficiary due to a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made.

Must the Plan allow payment for COBRA continuation coverage to be made in monthly installments? Yes. The Plan is also permitted to allow for payment at other intervals.

What is Timely Payment for payment for COBRA continuation coverage? Timely Payment means a payment made no later than 30 days after the first day of the coverage period. Payment that is made to the Plan by a later date is also considered Timely Payment if either under the terms of the Plan, covered employees or Qualified Beneficiaries are allowed until that later date to pay for their coverage for the period or under the terms of an arrangement between the Employer and the entity that provides Plan benefits on the Employer's behalf, the Employer is allowed until that later date to pay for coverage of similarly situated non-COBRA beneficiaries for the period.

Notwithstanding the above paragraph, the Plan does not require payment for any period of COBRA continuation coverage for a Qualified Beneficiary earlier than 45 days after the date on which the election of COBRA continuation coverage is made for that Qualified Beneficiary. Payment is considered made on the date on which it is postmarked to the Plan.

If Timely Payment is made to the Plan in an amount that is not significantly less than the amount the Plan requires to be paid for a period of coverage, then the amount paid will be deemed to satisfy the Plan's requirement for the amount to be paid, unless the Plan notifies the Qualified Beneficiary of the amount of the deficiency and grants a reasonable period of time for payment of the deficiency to be made. A "reasonable period of time" is 30 days after the notice is provided. If a shortfall in a Timely Payment is not significant if it is no greater than the lesser of $50 or 10% of the required amount.

**IF YOU HAVE QUESTIONS**

If you have questions about your COBRA continuation coverage, you should contact the Plan Administrator. 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). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

**KEEP YOUR PLAN ADMINISTRATOR 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.
Responsibilities for Plan Administration

PLAN ADMINISTRATOR. St. Francis Health Services Preventive Medical Services Plan is the benefit plan of St. Francis Health Services, and its Affiliates, the Plan Administrator, also called the Plan Sponsor. It is to be administered by the Plan Administrator in accordance with the provisions of ERISA. An individual may be appointed by St. Francis Health Services to be Plan Administrator and serve at the convenience of the Employer. If the Plan Administrator resigns, dies or is otherwise removed from the position, St. Francis Health Services shall appoint a new Plan Administrator as soon as reasonably possible.

The Plan Administrator shall administer this Plan in accordance with its terms and establish its policies, interpretations, practices, and procedures. It is the express intent of this Plan that the Plan Administrator shall have maximum legal discretionary authority to construe and interpret the terms and provisions of the Plan, to make determinations regarding issues which relate to eligibility for benefits, to decide disputes which may arise relative to a Plan Participant’s rights, and to decide questions of Plan interpretation and those of fact relating to the Plan. The decisions of the Plan Administrator will be final and binding on all interested parties.

Service of legal process may be made upon the Plan Administrator.

DUTIES OF THE PLAN ADMINISTRATOR.

1. To administer the Plan in accordance with its terms.
2. To interpret the Plan, including the right to remedy possible ambiguities, inconsistencies or omissions.
3. To decide disputes which may arise relative to a Plan Participant’s rights.
4. To prescribe procedures for filing a claim for benefits and to review claim denials.
5. To keep and maintain the Plan documents and all other records pertaining to the Plan.
6. To appoint a Claims Administrator to pay claims.
7. To perform all necessary reporting as required by ERISA.
8. To establish and communicate procedures to determine whether a medical child support order is qualified under ERISA Sec. 609.
9. To delegate to any person or entity such powers, duties and responsibilities as it deems appropriate.

PLAN ADMINISTRATOR COMPENSATION. The Plan Administrator serves without compensation; however, all expenses for plan administration, including compensation for hired services, will be paid by the Plan.

FIDUCIARY. A fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets, renders investment advice to the Plan or has discretionary authority or responsibility in the administration of the Plan.

FIDUCIARY DUTIES. A fiduciary must carry out his or her duties and responsibilities for the purpose of providing benefits to the Employees and their Dependent(s), and defraying reasonable expenses of administering the Plan. These are duties which must be carried out:

1. with care, skill, prudence and diligence under the given circumstances that a prudent person, acting in a like capacity and familiar with such matters, would use in a similar situation;
2. by diversifying the investments of the Plan so as to minimize the risk of large losses, unless under the circumstances it is clearly prudent not to do so; and
3. in accordance with the Plan documents to the extent that they agree with ERISA.
THE NAMED FIDUCIARY. A "named fiduciary" is the one named in the Plan. A named fiduciary can appoint others to carry out fiduciary responsibilities (other than as a trustee) under the Plan. These other persons become fiduciaries themselves and are responsible for their acts under the Plan. To the extent that the named fiduciary allocates its responsibility to other persons, the named fiduciary shall not be liable for any act or omission of such person unless either:

(1) the named fiduciary has violated its stated duties under ERISA in appointing the fiduciary, establishing the procedures to appoint the fiduciary or continuing either the appointment or the procedures; or

(2) the named fiduciary breached its fiduciary responsibility under Section 405(a) of ERISA.

FUNDING THE PLAN AND PAYMENT OF BENEFITS

The cost of the Plan is funded as follows:

For Employee and Dependent Coverage: Funding is derived from the funds of the Employer and contributions made by the covered Employees.

The level of any Employee contributions will be set by the Plan Administrator. These Employee contributions will be used in funding the cost of the Plan as soon as practicable after they have been received from the Employee or withheld from the Employee's pay through payroll deduction.

Benefits are paid directly from the Plan through the Claims Administrator.

CLERICAL ERROR

Any clerical error by the Plan Administrator or an agent of the Plan Administrator in keeping pertinent records or a delay in making any changes will not invalidate coverage otherwise validly in force or continue coverage validly terminated. An equitable adjustment of contributions will be made when the error or delay is discovered.

If, due to a clerical error, an overpayment occurs in a Plan reimbursement amount, the Plan retains a contractual right to the overpayment. The person or institution receiving the overpayment will be required to return the incorrect amount of money. In the case of a Plan Participant, if it is requested, the amount of overpayment will be deducted from future benefits payable.

AMENDING AND TERMINATING THE PLAN

If the Plan is terminated, the rights of the Plan Participants are limited to expenses incurred before termination.

The Employer intends to maintain this Plan indefinitely; however, it reserves the right, at any time, to amend, suspend or terminate the Plan in whole or in part. This includes amending the benefits under the Plan or the Trust agreement (if any).
Certain Plan Participants Rights under ERISA

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

Examine, without charge, at the Plan Administrator’s office, all Plan documents and copies of all documents governing the Plan, including a copy of the latest annual report (form 5500 series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

 Continue health care coverage for a Plan Participant, Spouse, or other dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. Employees or dependents may have to pay for such coverage.

 Review this summary plan description and the documents governing the Plan or the rules governing COBRA continuation coverage rights.

 The Employee or dependent should be provided a certificate of Creditable Coverage, free of charge, from the group health plan or health insurance issuer when coverage is lost under the plan, when a person becomes entitled to elect COBRA continuation coverage, when COBRA continuation coverage ceases, if a person requests it before losing coverage, or if a person requests it up to 24 months after losing coverage.

 If a Plan Participant's claim for a benefit is denied or ignored, in whole or in part, the participant has a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

 Under ERISA, there are steps a Plan Participant can take to enforce the above rights. For instance, if a Plan Participant requests a copy of Plan documents or the latest annual report from the Plan and does not receive them within 30 days, he or she may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the Plan Participant up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If the Plan Participant has a claim for benefits which is denied or ignored, in whole or in part, the participant may file suit in state or federal court.

 In addition, if a Plan Participant disagrees with the Plan’s decision or lack thereof concerning the qualified status of a medical child support order, he or she may file suit in federal court.

 In addition to creating rights for Plan Participants, ERISA imposes obligations upon the individuals who are responsible for the operation of the Plan. The individuals who operate the Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of the Plan Participants and their beneficiaries. No one, including the Employer or any other person, may fire a Plan Participant or otherwise discriminate against a Plan Participant in any way to prevent the Plan Participant from obtaining benefits under the Plan or from exercising his or her rights under ERISA.

 If it should happen that the Plan fiduciaries misuse the Plan’s money, or if a Plan Participant is discriminated against for asserting his or her rights, he or she may seek assistance from the U.S. Department of Labor, or may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the Plan Participant is successful, the court may order the person sued to pay these costs and fees. If the Plan Participant loses, the court may order him or her to pay these costs and fees, for example, if it finds the claim or suit to be frivolous.

 If the Plan Participant has any questions about the Plan, he or she should contact the Plan Administrator. If the Plan Participant has any questions about this statement or his or her rights under ERISA, including COBRA or the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, that Plan Participant should contact either the nearest Regional or District Office of the U.S. Department of Labor’s Employee Benefits Security Administration (EBSA) or visit the EBSA website at www.dol.gov/ebsa/. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.)
Compliance with HIPAA Privacy Standards

Certain members of the Employer's workforce perform services in connection with administration of the Plan. In order to perform these services, it is necessary for these employees from time to time to have access to Protected Health Information (as defined below).

Under the Standards for Privacy of Individually Identifiable Health Information (45 CFR Part 164, the "Privacy Standards"), these employees are permitted to have such access subject to the following:

(1) **General.** The Plan shall not disclose Protected Health Information to any member of the Employer's workforce unless each of the conditions set out in this HIPAA Privacy section is met. "Protected Health Information" shall have the same definition as set out in the Privacy Standards but generally shall mean individually identifiable health information about the past, present or future physical or mental health or condition of an individual, including information about treatment or payment for treatment.

(2) **Permitted Uses and Disclosures.** Protected Health Information disclosed to members of the Employer's workforce shall be used or disclosed by them only for purposes of Plan administrative functions. The Plan's administrative functions shall include all Plan payment and health care operations. The terms "payment" and "health care operations" shall have the same definitions as set out in the Privacy Standards, but the term "payment" generally shall mean activities taken with respect to payment of premiums or contributions, or to determine or fulfill Plan responsibilities with respect to coverage, provision of benefits, or reimbursement for health care. "Health care operations" generally shall mean activities on behalf of the Plan that are related to quality assessment; evaluation, training or accreditation of health care providers; underwriting, premium rating and other functions related to obtaining or renewing an insurance contract, including stop-loss insurance; medical review; legal services or auditing functions; or business planning, management and general administrative activities.

(3) **Authorized Employees.** The Plan shall disclose Protected Health Information only to members of the Employer's workforce, who are designated and are authorized to receive such Protected Health Information, and only to the extent and in the minimum amount necessary for these persons to perform duties with respect to the Plan. For purposes of this HIPAA Privacy section, "members of the Employer's workforce" shall refer to all employees and other persons under the control of the Employer.

(a) **Updates Required.** The Employer shall amend the Plan promptly with respect to any changes in the members of its workforce who are authorized to receive Protected Health Information.

(b) **Use and Disclosure Restricted.** An authorized member of the Employer's workforce who receives Protected Health Information shall use or disclose the Protected Health Information only to the extent necessary to perform his or her duties with respect to the Plan.

(c) **Resolution of Issues of Noncompliance.** In the event that any member of the Employer's workforce uses or discloses Protected Health Information other than as permitted by the Privacy Standards, the incident shall be reported to the privacy official. The privacy official shall take appropriate action, including:

(i) Investigation of the incident to determine whether the breach occurred inadvertently, through negligence, or deliberately; whether there is a pattern of breaches; and the degree of harm caused by the breach;

(ii) Applying appropriate sanctions against the persons causing the breach, which, depending upon the nature of the breach may include, oral or written reprimand, additional training, or termination of employment;

(iii) Mitigating any harm caused by the breach, to the extent practicable; and

(iv) Documentation of the incident and all actions taken to resolve the issue and mitigate any damages.
(4) **Certification of Employer.** The Employer must provide certification to the Plan that it agrees to:

(a) Not use or further disclose the Protected Health Information other than as permitted or required by the Plan documents or as required by law;

(b) Ensure that any agent or subcontractor, to whom it provides Protected Health Information received from the Plan, agrees to the same restrictions and conditions that apply to the Employer with respect to such information;

(c) Not use or disclose Protected Health Information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Employer;

(d) Report to the Plan any use or disclosure of the Protected Health Information of which it becomes aware that is inconsistent with the uses or disclosures hereunder or required by law;

(e) Make available Protected Health Information to individual Plan members in accordance with Section 164.524 of the Privacy Standards;

(f) Make available Protected Health Information for amendment by individual Plan members and incorporate any amendments to Protected Health Information in accordance with Section 164.526 of the Privacy Standards;

(g) Make available the Protected Health Information required to provide any accounting of disclosures to individual Plan members in accordance with Section 164.528 of the Privacy Standards;

(h) Make its internal practices, books and records relating to the use and disclosure of Protected Health Information received from the Plan available to the Department of Health and Human Services for purposes of determining compliance by the Plan with the Privacy Standards;

(i) If feasible, return or destroy all Protected Health Information received from the Plan that the Employer still maintains in any form, and retain no copies of such information when no longer needed for the purpose of which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information unfeasible; and

(j) Ensure the adequate separation between the Plan and member of the Employer's workforce, as required by Section 164.504(f)(2)(iii) of the Privacy Standards.

The following members of St. Francis Health Services workforce are designated as authorized to receive Protected Health Information from St. Francis Health Services Preventive Medical Services Plan ("the Plan") in order to perform their duties with respect to the Plan: Benefits Manager and appointed staff.