BJC Total Rewards

Benefits • Career • Compensation • Recognition • Work-Life

2022 Benefits

SUMMARY PLAN DESCRIPTIONS

- Medical
- Pharmacy
- Dental
- Vision
- Flexible Spending Accounts
- Life and AD&D
- Short-Term Disability
- Long-Term Disability
- Legal Services
- Business Travel Accident
- Employee Assistance Program (EAP)

Table of Contents

HEALTH CARE BENEFITS 7
- Your Health Care Options 7
- Eligibility and Enrollment Process 7
  - *Employee Eligibility 7*
  - *Employee Eligibility - Affordable Care Act (ACA) 7*
  - *Dependent Eligibility 8*
  - *Enrollment Process 9*
  - *Dependent Eligibility Verification 9*
  - *When Coverage Begins for Employees 10*
  - *When Coverage Begins for Your Dependents 10*
  - *If You Change BJC Employers 10*
  - *Late Enrollment 10*
  - *Coverage Costs 11*
  - *Working Spouse Surcharge 11*
  - *Pre-Tax Advantage 11*

MEDICAL 13
- BJC Medical Options 13
- Wellness Programs: Promoting Better Health 13
  - *Health Risk Assessment (HRA) 13*
  - *Tobacco Cessation 14*
  - *Weight Management Programs 14*
  - *Diabetes Management Program 15*
- Care Management Programs 15
  - *BJC Care Management 15*
  - *Sleep Improvement 15*
- Schedule of Benefits – BJC Medical Plan Options 16
- Providers 19
  - *Signature (EPO) Providers 19*
  - *Choice Plus and Choice (PPO) Providers 19*
- Deductibles, Copayments, Coinsurance and Maximums 20
  - *Annual Deductibles 20*
  - *Flat Dollar Copayments (Copayments) 21*
  - *Percentage Coinsurance (Coinsurance) 21*
  - *Annual Out-of-Pocket Maximum 22*
- Services Requiring Prior Authorization 22
  - *Services Requiring Prior Authorization from the Benefits Manager 22*
  - *Initial Determination by the Benefits Manager 23*
  - *Concurrent Review Determinations 23*
  - *Retrospective Review Determinations 23*
- Covered Medical Services 24
- Medical Exclusions 39
- Claims Filing, Second Opinions and Utilization Review Procedures 45
  - *Claims for Benefits 45*
  - *Second Opinions 45*
  - *Utilization Review Procedures 45*
- Glossary of Medical Plan Terms 45

PHARMACY PROGRAM 53
- *How the Plan Works 53*
- *Choosing a Brand drug when a Generic is Available 53*
- *Helpful Hints for Using Your Pharmacy Benefits 54*
- Schedule of Benefits - Pharmacy 54
  - *Annual Out-of-Pocket Maximum 54*
- Description of Covered Drugs 55
  - *Fertility Drugs 55*
- Types of Drugs 56
  - *Generic Drugs 56*
  - *Preferred Brand-Name Drugs and Non-Preferred Brand-Name Drugs 56*
  - *Generic Drug Requirement 56*
  - *Specialty Drugs 56*
- Pharmacies You Can Use 56
  - *Family Care Central Pharmacy 57*
  - *Family Care Central Pharmacy Requirement 57*
- Prior Authorizations and Drug Quantity Limits 57
  - *Prior Authorization for Specialty Drugs 57*
  - *SaveonSP Savings Program for Specialty Drugs 57*
  - *Prior Authorization for Certain Drugs 58*
  - *Step Therapy 58*
  - *Quantity Limits 58*
- Emergency Fill Program 58
- Maintenance Medications 58
  - *How the Plan Defines a Maintenance Drug 59*
  - *Refill Rule 59*
- Pharmacy Exclusions 59
- Pharmacy Locations 60
  - *BJC Pharmacy Locations 60*
  - *Select Out-of-Area Pharmacy Locations 61*
  - *Participating Walgreens Pharmacy Locations 61*

Pharmacy Claims Procedures 61
Filing a Claim 62
IMPORTANT NOTICE FROM BJC HEALTHCARE ABOUT 63
YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE 63
When Can you Join a Medicare Drug Plan? 63
What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan? 63
When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan? 63
For More Information About This Notice or Your Current Prescription Drug Coverage… 64
For More Information About Your Options Under Medicare Prescription Drug Coverage…..... 64
DENTAL 65
Dental Options for BJC Employees 65
Schedule of Benefits - Dental for High and Low Options 65
The Deductible 65
Annual and Lifetime Maximums 65
Providers 66
Claim Predetermination 66
Covered Dental Services 66
Dental Plan Exclusions and Limitations 68
Filing Dental Claims 70
Glossary of Dental Terms 70
VISION 72
Coverage Categories 72
Schedule of Benefits--Vision 72
VSP Provider Network: VSP Signature 72
Providers 73
VSP Providers - Network Care 73
Non-VSP Providers (Out-of-Network) Care 73
Covered Vision Services 73
Vision Exclusions 75
How to File a Vision Claim 76
Questions About Your Claim 76
Payment of Claims 76
When and Where to File 76
CLAIMS AND ELIGIBILITY APPEALS 77
Eligibility and Enrollment Appeals 77
Claims Appeal Procedures - Medical/Pharmacy/Dental . 77
Submitting Claims 77
Initial Claims Determinations 78
If Your Claim Is Denied 79
Review of Denied Claims 80
Timeframes for Medical, Pharmacy and Dental Claims Appeals 81
Determinations on Appeal for Medical, Pharmacy and Dental Claims 82
External Review After Exhaustion of Plan's Internal Appeals Process (Medical and Pharmacy Claims Appeals only - not applicable to Dental Claims Appeals) 83
Expedited External Review Process (Medical and Pharmacy Claims Appeals only - not applicable to Dental Claims Appeals) 84
Designation of an Authorized Representative 85
Limitation on Actions 85
No Assignment 86
Inquiry and Grievance Procedure for Non-Claim Medical Plan Issues 86
Inquiries 86
Grievance Procedure 86
Claims and Grievance Procedures for Vision Coverage . 87
Initial Claims Determinations 87
If Your Claim is Denied 87
Determinations on Appeal for Vision Claims 87
Limitation on Actions 88
COORDINATION OF BENEFITS 89
Coordination with Other Plans 89
BJC HealthCare Medical and Dental Plan 89
BJC Healthcare Vision Plan 90
Right of Recovery 90
TERMINATION OF COVERAGE 93
For Medical (including Pharmacy), Dental and Vision Coverage 93
When Employee Coverage Ends 93
When Qualified Dependent Coverage Ends 93
Retroactive Termination 93
During a Leave of Absence 94
COBRA 94
When COBRA Continuation Coverage Is Available ... 94
You Must Give Notice of Some Qualifying Events 95
Duration of COBRA Coverage 95

Extension of the 18-Month Period of Continuation Coverage 96
Electing COBRA Continuation Coverage 97
Paying for COBRA Continuation Coverage 97
When COBRA Continuation Coverage Ends 98
If You Have Questions 98
Keep BJC Informed of Address Changes 98
How to Contact the COBRA Administrator 98
USERRA 99
If You Are on a Military Leave 99
LEGAL NOTICES 100
HIPAA 100
HIPAA Privacy Rights 100
HIPAA Special Enrollment Rights 100
FLEXIBLE SPENDING ACCOUNTS 102
Eligibility 102
Enrollment Process 102
When Coverage Begins and Ends 103
When Coverage Begins for Employees 103
When Coverage Ends 103
Health Care Flexible Spending Account (FSA) 103
Health Care FSA Eligible and Ineligible Expenses 104
Taxation 105
Dependent Care Flexible Spending Account (FSA) 105
Dependent Care FSA Eligible Expenses 106
Dependent Care FSA Ineligible Expenses 106
Taxation 107
Choosing the Best Tax Advantage for Dependent Care 107
Understanding the Federal Dependent Care Tax Credit 107
Special Health Care FSA and Dependent Care FSA Rules 108
FSA Debit Card 109
Debit Card Claims Substantiation Requirements 110
Requesting Reimbursement 111
Claims Appeal Procedures – Flexible Spending Accounts (FSAs) 111
Initial Claims Determinations 111
If Your Claim Is Denied 112
Review of Denied Claims 112
Limitation on Actions 113
LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE 114
Life and AD&D Insurance Options 114
Eligibility and Enrollment Process 114
Employee Eligibility 114
Dependent Eligibility 115
Enrollment Process 115
If You Change BJC Employers 116
Certificates of Coverage from Insurance Carrier 116
When Your Life, AD&D and Dependent Life Coverage Ends 116
Evidence of Insurability 117
Coverage Costs 117
Basic and Supplemental Life and AD&D Coverage 117
Additional AD&D Coverage 117
Dependent Life Coverage 117
The Pre-Tax Advantage 118
Naming a Beneficiary 118
Life and AD&D 118
Dependent Life 118
Additional AD&D 118
Changing Your Life and AD&D Insurance Coverage 118
Changing Your Dependent Life Insurance Coverage 119
Claims Procedures and Appeals for Life and AD&D Insurance 119
Filing a Claim 119
Initial Claims Determinations 120
Review of Denied Claims (Claims Appeals Procedures) 121
Notification of Decision 122
Limitation on Actions 122
Designation of an Authorized Representative 122
SHORT-TERM DISABILITY 123
Eligibility 123
When Coverage Begins and Ends 123
When Coverage Begins 123
When Coverage Ends 124
Continuation of Coverage if You Are Disabled 124
Coverage Costs 124
Schedule of Benefits - Short-Term Disability (STD) 124
If You Change BJC Employers 125

When Benefit Payments Begin and End 125
Definition of Disability 125
Disability Benefits 126
Payment of Benefits 126
Calculating Your Weekly Benefit 126
Coordinating with Other Income-Replacement Benefits 126
Return to Work Incentive Benefit 128
Overpayment of Benefits 128
How Long Benefits Are Paid (Maximum Period of Payment) 128
To Whom Payable 129
If You Become Disabled Again After You Return to Work (Successive Periods of Disability) 129
Exclusions and Limitations 129
Exclusions 129
Claims and Appeal Procedures - STD 130
How to File a Claim 130
Initial Claims Determinations 130
Review of Denied Claims (Appeals) 131
Notice of Decision 132
Limitation on Actions 132
Designation of an Authorized Representative 133
Glossary of STD Terms 133
LONG-TERM DISABILITY 135
Eligibility and Enrollment Process 135
Eligibility 135
Enrollment Process – New Hire/Status Changes 136
Annual Enrollment 136
If You Change BJC Employers 136
Certificates of Coverage from Insurance Carrier 136
Classes of Employees 137
When Coverage Ends 137
Continuation of Coverage if You Are Disabled 138
Coverage Costs 138
The Pre-Tax Advantage 138
Claims and Appeal Procedures - LTD 139
How to File a Claim 139
Initial Claims Determinations 140
Review of Denied Claims (Appeals) 141
Notice of Decision 141
Limitation on Actions 142
Designation of an Authorized Representative 142
Glossary of LTD Terms (See also LTD Definitions in Your Certificate of Coverage) 142
OTHER BENEFITS 143
Legal Services Plan 143
Eligibility and Enrollment 143
Annual Enrollment 144
When Coverage Begins 144
When Coverage Ends 144
Obtaining Legal Services 145
What Services are Covered 146
Appendix A - Definition of Covered Services 146
Appendix B (Plus Parents buy up option) 152
Exclusions 154
Glossary of Legal Services Terms 154
Amendment or Termination 154
Administration and Funding 155
Cost of the Plan 155
Plan Confidentiality, Ethics, and Independent Judgment 155
Other Special Rules 155
Denials of Benefits and Appeal Procedures 156
Limitation on Actions 156
Business Travel Accident (BTA) 158
Eligibility 158
When Coverage Ends 158
BTA Benefits Paid by the Plan 158
BTA Definitions 159
Amount of BTA Coverage 160
Naming a Beneficiary 160
BTA Exclusions 160
Claims Procedures for Business Travel Accident Insurance 161
Designation of an Authorized Representative 162
Employee Assistance Program 163
Eligibility 163
When Coverage Begins and Ends 163
The Cost of Your Coverage 163
EAP Benefits Available 163
How to Obtain Benefits 164

PLAN ADMINISTRATION....165
Changing Coverage....168
When You Can Change Your Coverage ("Qualified Change in Status Events")....168
ERISA RIGHTS....172
Receive Information about Your Plan and Benefits....172
Continue Group Health Plan Coverage....172
Prudent Actions by Plan Fiduciaries....172
Enforce Your Rights....173
Assistance with Your Questions....173
LIMITATION ON ACTIONS....173
DISCLAIMER....174
STANDARD OF REVIEW....174

HEALTH CARE BENEFITS

Your Health Care Options

- Medical/Pharmacy
- Dental
- Vision

Your health care options include a choice of medical coverage options, a prescription drug benefit, a choice of dental coverage options, and vision coverage.

Eligibility and Enrollment Process

Employee Eligibility

You are eligible to participate in the medical (including pharmacy), dental and vision Plans if you are classified in BJC HealthCare's payroll system as a regular full-time employee who works at least thirty-five (35) hours per week (seventy (70) hours per pay period), or as a regular part-time employee who works at least twenty-four (24) hours per week (forty-eight (48) hours per pay period), regardless of retroactive reclassification.

Except as otherwise provided below, part-time employees working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), PRN and per diem employees, and temporary employees whose hours are variable or not expected to exceed thirty (30) hours per week are not eligible to participate in the medical (including pharmacy) Plan.

For purposes of initial eligibility, the term "works" within this Summary Plan Description (SPD) means the budgeted hours in BJC's payroll system and not the hours actually worked. In order to maintain and continue eligibility under the Plans after your initial eligibility date, you must continue to actually work a minimum of: thirty-five (35) hours per week (seventy (70) hours per pay period) if you are a regular full-time employee or twenty-four (24) hours per week (forty-eight (48) hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare's payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee's audit to update an employee's eligibility status based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include Paid Time Off (PTO), Short Term Disability (STD), low census, and unpaid approved leave hours.

Employee Eligibility - Affordable Care Act (ACA)

Initial Measurement/Stability Period

If you are classified in BJC's payroll system as a part-time working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), a PRN or per diem employee, or a temporary employee whose hours are variable or not expected to exceed thirty (30) hours per week, you are initially eligible to participate in the medical (including pharmacy) Plan beginning on the first day of the month from the first anniversary of your hire date *if* you averaged at least thirty (30) hours of eligible service per week during your first twelve (12) months of employment (Initial Measurement Period ("IMP")). You will continue to be eligible to participate for twelve (12) consecutive months (also known as an Initial Stability Period ("ISP")) provided you continue to be employed by BJC regardless of how many hours you work. For example, if you are classified as a PRN employee, are hired on June 15, 2021, and you averaged at least thirty (30) hours of eligible service per week during your first twelve (12) months of employment, ending on June 14, 2022, you are initially eligible to participate in the medical (including pharmacy) Plan beginning July 1, 2022 for twelve (12) consecutive months.

Standard Measurement/Stability Period

On an ongoing basis, if you are classified in BJC's payroll as part-time working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), a PRN or per diem employee, or a temporary employee whose hours are variable or not expected to exceed thirty (30) hours per week, you will be eligible to participate in the medical (including pharmacy) Plan during a Plan Year *if* you averaged at least thirty (30) hours of service per week during a designated twelve (12) month period ending in October of the year preceding the Plan Year (also referred to as the Standard Measurement Period ("SMP")). You will continue to be eligible to participate until the end of the Plan Year provided you continue to be employed by BJC regardless of how many hours you work during the Plan Year (also referred to as a Standard Stability Period ("SSP")). For example, if you are classified as a PRN employee, are an existing employee, and you averaged at least thirty (30) hours of eligible service per week during the twelve (12) month period ending in October 2021, you would be eligible to participate in the medical (including pharmacy) Plan for the entire 2022 Plan Year beginning January 1, 2022 through December 31, 2022, as long as you continue to be employed by BJC.

Hours of service for purposes of determining eligibility of a part-time working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), temporary, PRN or per diem employee means each hour for which the employee is paid or entitled to payment either for services performed or for PTO (e.g., vacation, holiday, etc.) illness, incapacity, layoff, jury duty or military duty or leave of absence.

BJC's intent is that part-time working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), temporary, PRN and per diem employees will be eligible to participate in the medical (including pharmacy) Plan if they are "full-time employees" as determined under the Affordable Care Act ("ACA"). These eligibility provisions will be applied and interpreted accordingly.

Part-time employees working less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), temporary, PRN and per diem employees are not eligible to participate in the dental and vision Plans.

Dependent Eligibility

Your dependents eligible for coverage under the medical (including pharmacy), dental and vision Plans include:

- Your spouse. For purposes of the medical, dental and vision Plans described in this SPD, an individual will be treated as your "spouse" only if you and such individual are lawfully married (as determined under applicable law at the time and location where the marriage was performed). The marriage must be memorialized by a marriage certificate issued by an entity entrusted with the appropriate legal authority to recognize such marriage.
- Your child or children up to the age of twenty-six (26).
- Your permanently and totally disabled unmarried child age twenty-six (26) or older, provided the disability began before he or she reached the limiting age for coverage under the Plans. A child is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months. You must provide proof of the disability within thirty-one (31) days after the date your child reaches the limiting age of twenty-six (26) (your child must be covered under the Plan when he or she reaches the limiting age) and as requested by the Benefits Manager. The child is not required to have the same principal place of abode as you. However, if the child does not have the same principal place of abode as you, he or she must receive over one-half of his or her support from you.

For purposes of the medical (including pharmacy), dental and vision Plans, "child" means:

- The employee's natural child, step-child, legally adopted child or a child placed with the employee for adoption.
- Any other child (including a grandchild) who has been placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

If you and your spouse are both eligible employees under the medical, dental and vision Plans, only one of you may cover a dependent child. In addition, you may not be enrolled as both an employee and as a dependent at the same time.

Newborn or Newly Adopted Child Eligibility

In order for your newborn or newly adopted child to be covered under the Plan(s) from birth, adoption, or placement for adoption, you must submit your enrollment to add the child as a dependent within sixty (60) days from the date of birth, adoption, or placement for adoption. Contact the Employee Service Center at 314-362-2184/855-362-2184 for additional information or assistance with enrollment. If you fail to complete the required enrollment within sixty (60) days, you will not be able to enroll the child until the next annual enrollment period unless you experience a qualified change in status event. These events are described in the section *Changing Coverage* if the child is an eligible dependent of the employee.

Qualified Medical Child Support Orders

A court may order you to provide coverage for your eligible dependent child in accordance with a qualified medical child support order (QMCSO). If the Plan receives a valid QMCSO, it will extend coverage to the eligible child named in the order. You will be notified if such an order is received, and you will be required to pay any applicable contributions for such coverage. You may obtain from the BJC Plan Administrator, without charge, a more detailed description of the procedures governing QMCSO determinations.

Enrollment Process

If you are a regular full-time or regular part-time employee, you must complete your enrollment for you and your dependent(s) no later than thirty-one (31) days after your hire date for a new hire. For this purpose, "hire date" means the date you are first classified as an employee in the payroll system. If you experience a qualified change in status event as indicated in the *Changing Coverage* section of this SPD, you must complete your enrollment for you and your dependent(s) no later than thirty-one (31) days after your change in status event date (sixty (60) days in the case of certain special enrollment events under the Children's Health Insurance Program and Reauthorization Act or if the event is your child's birth, adoption, or placement for adoption). If you are a part-time employee who works less than twenty-four (24) hours per week (less than forty-eight (48) hours per pay period), a PRN or per diem employee, or a temporary employee whose hours are variable or not expected to exceed 30 hours per week, and you become eligible to participate in the medical (including pharmacy) Plan after averaging at least thirty (30) hours of service per week during your first twelve (12) months of employment, you must complete your enrollment for you and your dependent(s) no later than thirty-one (31) days after the date you are notified you are eligible.

NOTE: If an election is not made in a timely manner, it will be assumed that you do not wish to elect coverage and you and/or your eligible dependents will not be enrolled in a health care option.

Annual Enrollment

Annually during fall, eligible employees have the opportunity to make new benefit elections for the following calendar/Plan year. Employees can change their elections on the designated web site only during the specified time period. Generally, if a new benefit election is not made in a timely manner for the following year, coverage will default as specified in the Annual Enrollment communication materials. Annual Enrollment communication materials may require an affirmative election to receive coverage for the following Plan Year, meaning that if you do not complete an election you might not be eligible for certain coverages. For additional information, please refer to these materials on BJCtotalrewards.org.

Dependent Eligibility Verification

If you are enrolling any new dependents for benefits coverage (e.g., during new employee enrollment, annual enrollment, change in status event), you are required to verify their eligibility for benefits coverage. This means that you will need to provide documentation verifying their eligibility under the Plan requirements. In addition, from time to time, you may be required to re-verify the eligibility of your covered dependents.

The Plan Administrator or its third-party designee will send a dependent eligibility verification packet to you informing you of the following: what documentation is required to verify your dependents' eligibility for coverage under the Plan, when you have to submit the documentation, and to whom to submit the documentation. Notwithstanding anything to the contrary contained in this SPD, if you are unable or unwilling to produce the required documentation in the required

timeframes, any unverified dependents will be removed from coverage under the Plan as of the end of the month for which you had to complete the verification process.

When Coverage Begins for Employees

Your coverage will be effective on the first day of the month following your hire date, provided that you have timely enrolled. Notwithstanding the foregoing, if you are not a regular full-time nor a regular part-time employee, and you become eligible after averaging at least thirty (30) hours of work per week during the first twelve (12) months of employment, your medical (including pharmacy) coverage will be effective on the first day of the month from the first (1st) anniversary of your hire date, provided that you have timely enrolled.

For medical resident house staff employees (through the GME office), your medical (including pharmacy) coverage will be effective on your hire date, provided that you have timely enrolled, but your dental and/or vision coverage, if any, will be effective the first day of the month following your hire date, provided that you have timely enrolled.

If you experience a qualified change in status event during the Plan year, your coverage will be effective on the first day of the month on or after the date of your change in status event, provided you have timely enrolled you and your dependent(s). You must enroll no later than thirty-one (31) days after your change in status event date (sixty (60) days in the case of a special enrollment right under the Children's Health Insurance Program and Reauthorization Act or if the event is your child's birth, adoption, or placement for adoption). You will not be permitted to change your coverage until the next annual enrollment period for the subsequent Plan Year except as described in the *Late Enrollment* section.

When Coverage Begins for Your Dependents

Coverage for your eligible dependents begins on the same day as your coverage, provided you have timely enrolled them in the Plans. You must enroll them no later than (a) thirty-one (31) days after your hire date (or the date you are notified you are eligible as described above in the *Employee Eligibility – Affordable Care Act* section), or (b) no later than thirty-one (31) days after you experience a qualified change in status event (60 days in the case of a special enrollment right under the Children's Health Insurance Program and Authorization Act). Notwithstanding the preceding sentence, if the change in status event is the birth, adoption, or placement for adoption of a child, coverage will be effective on the date of birth, adoption, or placement for adoption, as long as you timely enroll no later than sixty (60) days after such date.

The BJC Plan Administrator reserves the right to request supporting documents consistent with the enrollment of dependents. If you do not provide such documentation within the required time period, your dependent(s) will not be enrolled in coverage.

If you acquire a new dependent through marriage while covered under the Plans, coverage for such dependent will begin on the first day of the month on or after the date of the change in status provided you timely enroll.

If you do not enroll your dependent when he or she is first eligible, you will not be permitted to enroll the dependent until the next annual enrollment period.

If You Change BJC Employers

If you are covered by the Plans when you change employment to another BJC HealthCare participating employer that offers the same coverage, your coverage and the coverage of any dependent who is covered and who is eligible for coverage with your new employer will be continuous (any deductibles or Plan year maximums or limits will be carried over and will continue to apply). More details may be found in the *Plan Administration* section of this booklet.

Late Enrollment

If you do not enroll in the Plan within thirty-one (31) days of your hire date (or the date you are notified you are eligible as described above in the *Employee Eligibility – Affordable Care Act* section) or within thirty-one (31) days (or sixty (60) days, as applicable) of a qualified change in status event date, you will not be able to apply for coverage until the next annual enrollment period or until you have another change in status event. HIPAA enrollment rights are described in the *HIPAA Special Enrollment Rights* section. The circumstances under which you may enroll pursuant to a change in status event are described in the section of this SPD entitled *Changing Coverage*, which applies to employees and

eligible dependents. If you do not qualify for a special enrollment period or have an appropriate change in status event, you will not be permitted to change your coverage until the annual enrollment period for the subsequent Plan Year.

Coverage Costs

You and your employer share the cost of coverage for your medical (including pharmacy) and dental Plan coverage. You pay the full cost of your vision Plan coverage.

You can choose the options that are right for you each fall during the annual enrollment period.

Your medical/pharmacy, dental and vision contributions are deducted from your paycheck on a pre-tax basis if you are covering yourself and your eligible dependents who qualify for the pre-tax deduction.

Working Spouse Surcharge

Spouses who are eligible for their employer's group medical coverage but choose coverage under BJC's medical Plan will pay a "Working Spouse Surcharge" per pay period.

The amount of the Working Spouse Surcharge is communicated during enrollment and documented as part of the benefits enrollment process.

The Working Spouse Surcharge will not apply if: you do not enroll a spouse in a BJC medical Plan; you do not have a spouse; your spouse is self-employed and is not eligible for group medical coverage; your spouse is employed but is not eligible for or does not have access to group medical coverage from his/her employer; your spouse is not employed; your spouse is not employed and has access to medical coverage in a government sponsored medical plan such as Medicare/Medicaid or Tricare; your spouse is not employed and has access to medical coverage through a Retiree Medical Plan; or your spouse is employed by a BJC HealthCare entity.

The Plan Administrator or its third-party designee may require you to verify, and from time to time re-verify, whether you should be paying the Working Spouse Surcharge for your eligible spouse enrolled in BJC medical Plan.

The Plan Administrator or its third-party designee will send a verification packet to you identifying the documentation required to verify whether or not you should be paying the Working Spouse Surcharge and telling you when and where to submit the documentation. If you do not produce the required documentation when requested, you will be required to pay the Working Spouse Surcharge for your spouse's coverage through the end of the Plan Year as long as your spouse remains enrolled in the Plan.

Additional information you should know:

- The spousal surcharge applies regardless of the level of premium/contribution or level of benefits offered by the spouse's employer.
- If you choose to waive medical coverage for your spouse, you may still enroll your spouse in dental and vision benefits.
- Employees will verify if their spouse has access to their own group medical coverage by "e-signing" an online affidavit as part of the benefits enrollment process.

Pre-Tax Advantage

You pay for many of your BJC benefits on a pre-tax basis. This means the cost of your contributions are taken from your pay before federal and state income taxes are deducted. This lowers your pay, which means you owe less in taxes. There are some important facts you should be aware of regarding this special tax break:

In exchange for the tax break, the Internal Revenue Service (IRS) generally requires that your annual benefit elections for pre-tax benefits will be locked in for the entire Plan Year. There are exceptions to this rule if you have a qualified change in status event during the year, as described in the section of this SPD entitled *Changing Coverage*. A qualified change in status can be made if the required enrollment is submitted within thirty-one (31) days of the event (sixty (60) days in the case of a special enrollment right under the Children's Health Insurance Program and Authorization Act or if the event is your child's birth, adoption, or placement for adoption).

- Benefits that are based on the amount of your base salary, such as your disability, life and accidental death and dismemberment insurance, are generally not affected by your pre-tax deductions. These benefits are based on your base pay before any pre-tax deductions.
- Under federal law, you do not pay Social Security (FICA) taxes on the pre-tax money you set aside for benefits. You should be aware that this could mean reduced benefits when you become eligible for Social Security. This reduction is generally very small, however, and is typically outweighed by your current tax savings.

MEDICAL

BJC Medical Options

To serve the different personal and family needs of individuals, you are offered a choice of three (3) medical coverage options: the BJC Signature option, the BJC Choice Plus option and the BJC Choice option. The medical coverage options are administered by Cigna Health Care using the Cigna LocalPlus network for the Signature option, and the Open Access Plus (OAP) and the Cigna Behavioral Health (BH) provider networks for the Choice Plus and Choice options.

The Signature medical option is an exclusive provider organization (EPO). Services are covered only if you go to doctors, specialists, or hospitals in the Cigna LocalPlus network, except in emergencies. Most BJC and Washington University physicians are in the network. There are no tiers or out-of-network coverage.

The Choice Plus and Choice medical options are both a preferred provider organization (PPO). You can visit out-of-network providers for care, but your costs are lower if you stay in-network (Cigna OAP), and lowest when you use a BJC Facility for certain services.

Prescription drug benefits are provided through the Pharmacy Program (described later in this SPD) whether you choose the BJC Choice Plus or BJC Choice medical coverage option. The prescription drug benefits are the same regardless of the medical option in which you enroll. There are no out-of-network benefits under the *Pharmacy Program*; participating pharmacies must be used in order to receive coverage.

If you elect family coverage, your dependents will be enrolled in the same medical coverage option you choose for yourself.

The sections following the *Wellness Programs* section below describe your benefits under each of the medical options in easy-to-follow language.

Wellness Programs: Promoting Better Health

BJC partners with you to improve your health by offering programs and personal health care information to contribute to better health. Better health can improve your quality of life, both at home and at work, making it an important partnership. In order to receive wellness incentives, or avoid additional medical contributions, you and your covered spouse, if applicable, must complete specific wellness activities within the designated periods outlined and communicated by the Plan Administrator during annual enrollment. BJC has paused our Annual Wellness Incentive for 2022 as we consider a new approach to our wellness program in the future. However, BJC will continue to offer the wellness programs detailed in this section. We hope these wellness programs help you to achieve your health goals.

During annual enrollment, if you elect medical coverage, you will be required to certify that the information you are providing is true and accurate to the best of your knowledge, and that intentional falsification or significant omissions will be grounds for discipline including, but not limited to, termination of employment from BJC HealthCare, denial or retroactive termination of benefit coverage, and recoupment of benefits improperly paid.

Health Risk Assessment (HRA)

The confidential Health Risk Assessment (HRA) helps to identify potential health issues early and provides personalized information on how to improve your health. It encourages you to make healthier lifestyle choices, provides recommendations on when to receive preventive health service, and helps BJC plan wellness programs that reflect need.

All employees and spouses who enroll in a BJC medical Plan are encouraged to complete an annual HRA. The confidential HRA contains questions about your health and health habits. You will be asked to answer personal questions about your height, weight, blood pressure, cholesterol and blood sugar that will be confidentially analyzed to

create a “myhealth assessment profile” and wellness score, just for you. Some of the information (biometrics) needed to complete the HRA can be obtained by attending a BJC health screening or when you visit your physician for an annual physical. Upon completion of the HRA, participants are encouraged to share the myhealth assessment profile and wellness score with their physician.

Health Risk Assessment Biometrics

Following is a list of biometric information requested in the HRA:

- Height, Weight, Waist Circumference
- Systolic and Diastolic Blood Pressure (mmHg)
- Total and HDL Cholesterol (mg/dL)

Tobacco Cessation

BJC is committed to the promotion of healthy lifestyles for our employees, patients, and the community we serve. Lifestyle choices impact your health and the amount BJC, and your co-workers pay for medical coverage. BJC offers employees and their eligible dependents (age 18 and over) who use tobacco products access to enroll in the Quit For Life® tobacco cessation program. There will be no cost to you or your eligible dependents who enroll in the Quit For Life® tobacco cessation program as long as the individual enrolling is currently enrolled in a BJC medical Plan. BJC employees and dependents who are not enrolled in a BJC medical Plan and want to use Quit For Life® services will have the value of the program (as of January 1, 2022, the value is $365; this may change from time to time) added to the employee's paycheck as taxable income. You can enroll in the Quit For Life® program by going to quitnow.net/bjc or calling 866-784-8454.

Weight Management Programs

You and your eligible dependents may each only participate in one (1) Weight Management Program offered by BJC at a time.

Head to Toe

Head to Toe is St. Louis Children’s Hospital’s multidisciplinary weight management program for kids and teens, ages 8-17, and their families. This online program helps families learn to make healthier lifestyle choices. Setting goals, regular exercise, and healthy eating all make a positive impact on a child's self-esteem. In order to be eligible to participate in the Head to Toe program, you and your eligible dependent(s) must be enrolled in one (1) of the BJC medical options, your child(ren) must be ages 8 through 17, and you and your child(ren) must meet the participation requirements under the Head to Toe program.

The program is facilitated by a registered dietitian, a licensed social worker, and an exercise specialist. Kids and their parents/caregivers meet once a week in group classes for 17 sessions. Each week, one of the three disciplines is taught. In the social work classes, topics covered include family communication, body image, media literacy, and stress and coping skills. Portion size, reading nutrition labels, and eating away from home are all taught in the nutrition classes. The exercise classes include topics such as energy balance, aerobic exercise, strength training, and flexibility.

To better understand the needs of your child, families are asked to participate in an orientation session prior to enrolling in the class. This session is an opportunity for families to receive all the details for the class and enroll in the upcoming class. To learn more or to sign up for an orientation session, please call 314-454-KIDS (5437) or 800-678-KIDS (5437).

Omada®

Omada® is an online, weight-management program, clinically designed to help pre-diabetic participants reduce their risk of developing type-2 diabetes. Omada® guides you through a 16-week core curriculum with a personalized health coach, small group support, and digital tracking tools, among other tools. Visit omadahealth.com/bjc to learn more or apply.

In order to be eligible to participate in the Omada® program, you and your eligible dependent(s) must be enrolled in one of the BJC medical options, be 18 years of age or older, and you and any eligible, participating dependent(s) must meet the eligibility requirements as determined and communicated by Omada®. There is no cost to participate in this program.

Diabetes Management Program

Livongo for Diabetes

Livongo for Diabetes program is a health benefit that combines technology with coaching to help make living with diabetes easier. Visit welcome.livongo.com/BJC and use the registration code: BJC.

In order to be eligible to participate in the Livongo for Diabetes program, you and your eligible dependent(s) must be enrolled in one (1) of the BJC medical options, be 18 years of age or older and must have been diagnosed with type 1 or type 2 diabetes. There is no cost to participate in this program.

Eligible participants in the Livongo for Diabetes program will receive the Livongo connected glucose meter that uses cellular technology to automatically upload readings and provide real-time tips based on blood glucose data, as well as unlimited test strips and lancets shipped directly to you at no cost, with just the click of a button on your glucose meter. Eligible participants will also receive 24/7 real-time personalized support provided from the Livongo mobile app, secure website, and certified diabetes educators via phone, email, or text.

Care Management Programs

BJC utilizes care management programs to help improve the health and wellbeing of you and your family.

BJC Care Management

The BJC medical Plan partners with BJC HealthCare and the BJC Medical Group to provide eligible medical Plan participants with access to an innovative care management program designed to help deliver coordinated, comprehensive, and personalized care to our medical Plan participants.

If you are an eligible BJC medical Plan participant, you may be asked if you would like to utilize the care management services. This is a voluntary program. If you choose to engage in the program, you will be provided with enrollment materials and will be referred to a BJC care manager who will work closely with you to help you achieve improved health and wellness. Your care manager will serve as your advocate, providing meaningful, personalized care pathways to provide coordinated and individualized care management.

Sleep Improvement

Eligible BJC medical Plan participants can access a sleep improvement program called Sleepio. Sleepio provides tools and techniques to improve your sleep that are accessible on a computer, tablet, or phone. Employees and spouses enrolled in one of BJC HealthCare's medical Plan options are eligible to participate.

To get started, visit www.sleepio.com/bjc to take a two-minute test and get your Sleep Score. Then, over several weeks, during online sessions, a range of cognitive and behavioral techniques are introduced to improve your sleep. Each session lasts about 15 minutes and is tailored to your progress and goals. Between sessions, you will complete a simple online Sleep Diary to track your sleep and will receive reminders to help you stick to the course. Throughout the course, you are supported by a community of other users; online tools including relaxation audios; and a library of over 100 expert articles and guides that cover common sleep problem areas, such as pregnancy and sleep, shift work, jet lag and menopause.

For additional questions, please contact the Sleepio Team at hello@sleepio.com.

Schedule of Benefits – BJC Medical Plan Options

The table below shows some highlights of the coverage available for Plan Year 2022 in the Signature (EPO), Choice Plus (PPO) and Choice (PPO) medical coverage options. Additional details and coverage rules are found in separate sections of this SPD, such as *Covered Medical Services* and *Medical Exclusions*.

SCHEDULE OF BENEFITS - MEDICAL COPAYMENT*, COINSURANCE** AND ANNUAL DEDUCTIBLE SCHEDULE FOR ALL MEDICAL OPTIONS							
MEDICAL SERVICES	**SIGNATURE**	**CHOICE PLUS**			**CHOICE**		
	LocalPlus Network	BJC Facility	Cigna OAP Network	Out-of-Network	BJC Facility	Cigna OAP Network	Out-of-Network
ANNUAL DEDUCTIBLE / MAXIMUMS / COPAYMENT / COINSURANCE							
Annual Deductible (Per Calendar Year)							
• Individual • Individual + 1 • Individual + 2 or more	$600 $1,200 $1,800	$400 $800 $1,200	$900 $1,800 $2,700	$4,000 $8,000 $12,000	$900 $1,800 $2,700	$2,700 $5,400 $8,100	$6,000 $12,000 $18,000
Out-of-Pocket Maximum (Per Calendar Year)							
• Individual • Individual + 1 • Individual + 2 or more	$2,200 $4,400 $6,600	$1,500 $3,000 $4,500	$5,000 $10,000 $10,000	Unlimited	$4,000 $8,000 $9,200	$6,000 $12,000 $12,000	Unlimited
Lifetime Maximum	Unlimited	Unlimited					
Emergency Room	$250	$250			$300		
Necessary Ambulance Transportation	15% after deductible	$50			$50		
Urgent Care	$50	$50			$60		
PHYSICIAN SERVICES (There are no Physicians in the BJC Facility network ("N/A".) **Please Note**: A question that will guide whether the claim is subject to the Network Provider copayment is: "Who is going to issue the bill — the physician or the hospital/facility?"							
Wellness and Preventive Care	$0	$0	$0	50% after deductible	$0	$0	75% after deductible
Diagnostic / Non-Preventive Office Visit							
• Primary Care Physician	$15	N/A	$20	50% after deductible	N/A	$25	75% after deductible
• Specialist	$40	N/A	$50	60% after deductible	N/A	$60	75% after deductible
• Cigna Telehealth Connection: Virtual	$0	N/A	$0	Not Covered	N/A	$0	Not Covered
Physician / Professional / Technical Charges Billed by Physician (other than a preventive or diagnostic office visit)							
• Inpatient	Included in Inpatient copay	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
• Outpatient	Included in Inpatient copay	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
Immunizations – Without Office Visit	$0	$0	$0	50% after deductible	$0	$0	75% after deductible
Outpatient Short-Term Therapy Visit, Physical, Speech, Occupational, Aquatic • Facility • Office visit/setting	 $25 $25	 $0 N/A	 $50 $50	 60% after deductible	$0	$50	80% after deductible
Cardiac Rehabilitation Visit	$25	$20	$20	60% after deductible	$30	$30	80% after deductible
Pulmonary Rehabilitation Visit	$25	$0	$0	60% after deductible	$0	$0	80% after deductible
Chiropractic Care Visit 20 visits calendar year maximum Requires medical necessity	$25	N/A	$25	Not Covered	N/A	$25	Not Covered

MEDICAL SERVICES	SIGNATURE	CHOICE PLUS			CHOICE		
	LocalPlus Network	BJC Facility	Cigna OAP Network	Out-of-Network	BJC Facility	Cigna OAP Network	Out-of-Network
LABORATORY SERVICES							
Lab Performed as Part of Preventive/Wellness Care	$0	$0	$0	50% after deductible	$0	$0	75% after deductible
Lab Performed as Part of Diagnostic/Non-Preventive Care							
• Lab billed by physician							
• Office Visit	$15 / $40	N/A	$0	50% after deductible	N/A	$0	75% after deductible
• Physician Charges	0% no deductible	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
• Lab billed by hospital/facility							
• Inpatient	Included in Inpatient copay	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
• Outpatient (BJC Facility includes BJC pathologist/ physician charges)	0% no deductible	0% no deductible	50% after deductible	50% after deductible	0% no deductible	70% after deductible	75% after deductible
RADIOLOGY SERVICES							
Radiology Performed as Part of Preventive/Wellness Care	$0	$0	$0	50% after deductible	$0	$0	75% after deductible
Radiology Performed as Part of Diagnostic/Non-Preventive Care							
• Radiology billed by physician							
• Office Visit	$15 / $40	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
• Physician Charges	0% no deductible	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
• Radiology billed by hospital/facility							
• Inpatient	Included in Inpatient copay	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
• Outpatient (BJC Facility includes BJC physician charges)	0% no deductible	0% no deductible	50% after deductible	50% after deductible	0% no deductible	70% after deductible	75% after deductible
HOSPITAL SERVICES							
Hospital Technical Charges - Billed by Facility							
• Inpatient billed by facility	$200/day (max. 5 days)	0% after deductible	50% after deductible	60% after deductible	15% after deductible	70% after deductible	80% after deductible
• Outpatient billed by facility	$250	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
Inpatient Rehabilitative Therapy	$200/day (max. 5 days)	0% after deductible	50% after deductible	60% after deductible	15% after deductible	70%after deductible	80% after deductible
Outpatient Surgery	$250	0% after deductible	45% after deductible	60% after deductible	15% after deductible	70% after deductible	80% after deductible
Outpatient Chemotherapy (also applies to other outpatient services)							
• Technical charges billed by a hospital/facility	$250/visit	0% after deductible	50% after deductible	50% after deductible	15% after deductible	60% after deductible	75% after deductible
• Physician / Professional / Technical charges billed by physician	Included in Outpatient copay	N/A	25% after deductible	50% after deductible	N/A	50% after deductible	75% after deductible
SKILLED NURSING FACILITY							
Extended Skilled Nursing Facility 100 days calendar year maximum	15% after deductible	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
HOSPICE CARE							
Inpatient Hospice	15% after deductible	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
Outpatient Hospice	15% after deductible	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
HOME HEALTH CARE							
Home Health Services 120 days calendar year maximum	15% after deductible	0% after deductible	40% after deductible	50% after deductible	15% after deductible	60% after deductible	75% after deductible
Peritoneal Dialysis	15% after deductible	0% after deductible	20% after deductible	50% after deductible	15% after deductible	40% after deductible	75% after deductible

MEDICAL SERVICES	SIGNATURE	CHOICE PLUS			CHOICE		
	LocalPlus Network	BJC Facility	Cigna OAP Network	Out-of-Network	BJC Facility	Cigna OAP Network	Out-of-Network
MENTAL HEALTH AND SUBSTANCE ABUSE/ALCOHOLISM SERVICES							
Failure to obtain Prior Authorization, when required, may reduce benefits. For Prior Authorization or referrals for Alcoholism, Substance Abuse and Mental Health Services, please contact Cigna Behavioral Health by calling the toll-free number on your ID card. Cigna BH Providers **must be used** for In-Network Benefits. Pre-certification is required for all inpatient admissions.							
Inpatient Covered services include: semiprivate room & board, general nursing care, & related services & supplies, day treatment	$200/day (max. 5 days)	0% after deductible	50% after deductible	60% after deductible	15% after deductible	70% after deductible	80% after deductible
Outpatient Office Visit	$15	$20	$20	50% after deductible	$25	$25	75% after deductible
All other Outpatient Covered services include: partial hospitalization, intensive outpatient program	15% after deductible	0% after deductible	50% after deductible	60% after deductible	15% after deductible	70% after deductible	80% after deductible
Preventive Mental Health Testing and Evaluation	0% no deductible	0% no deductible	0% no deductible	50% after deductible	0% no deductible	0% no deductible	75% after deductible
Cigna Telehealth Connection (Virtual)	$0	N/A	$0	Not Covered	N/A	$0	Not Covered
FERTILITY SERVICES (7,500 Lifetime maximum per Member)							
Outpatient Office Visit	$40	$50	$50	50% after deductible	$60	$60	75% after deductible
Services billed by a hospital or facility • Inpatient • Outpatient	$200/day (max. 5 days) $250/visit	0% after deductible	50% after deductible	50% after deductible	15% after deductible	70% after deductible	75% after deductible
Inpatient/Outpatient Physician/ Professional charges billed by Physician	Included in Facility copay	25% after deductible	25% after deductible	50% after deductible	50% after deductible	50% after deductible	75% after deductible
OTHER COVERED SERVICES							
Wellness/Preventive Care	0% no deductible	0% no deductible	0% no deductible	50% after deductible	0% no deductible	0% no deductible	75% after deductible
Breastfeeding Equipment & Supplies Requires a prescription & must be ordered through a BJC Pharmacy or Cigna EviCore. Limit one (1) pump per birth.	$0	$0	$0	Not Covered	$0	$0	Not Covered
Diabetic Equipment & Supplies Requires a prescription & must be ordered through Cigna EviCore	0% no deductible	$0	$0	Not Covered	$0	$0	Not Covered
Nutritional Counseling In-Network Only: Up to $1000 calendar year max. After $1,000 max. has been met	$0 $40/session	$0 $50/session	$0 $50/session	50% after deductible	$0 $60	$0 $60	75% after deductible
Durable Medical Equipment (DME) and Prostheses Please refer to the DME List.	15% after deductible	0% after deductible	40% after deductible	50% after deductible	15% after deductible	60% after deductible	75% after deductible
Wig (hair loss due to chemotherapy) Limit one (1) wig per Lifetime.	15% after deductible	0% no deductible	0% no deductible	0% no deductible	0% no deductible	0% no deductible	0% no deductible
Other Covered Services not specifically listed above	15% after deductible	0% after deductible	50% after deductible	50% after deductible	15% after deductible	60% after deductible	75% after deductible

*Copayment is the flat dollar amount that the covered individual must pay directly to a provider or facility for Covered Medical Services. The member does not need to meet the annual deductible requirement (if applicable) in order for these services to be covered by the Plan if services are provided by LocalPlus, BJC Facility or Network providers. Only the applicable copayment will apply.

**Coinsurance is the percentage amount that the covered individual must pay directly to a provider or facility for Covered Medical Services. Any applicable deductible will be applied for services that have a percentage coinsurance before benefits will be paid.

Definitions:

Physician/Professional charges are charges for a physician or other licensed health care professional's time and expertise to provide healthcare services to an individual.

Technical charges are charges for the tools and services that a professional uses or a facility provides to provide healthcare services; such as equipment, supplies, operating room time, general nursing care, room and board, radiology, lab tests, chemotherapy, etc.

NOTES (applicable only to the Choice Plus and Choice medical options):

For a complete listing of the BJC Facilities, please refer to the Glossary of Medical Terms section in this SPD. For DME, only BJC Home Care is considered a BJC Facility.

- Both Physician/Professional and Technical charges may be billed by a physician's office, hospital, or other healthcare provider, depending on the services that they are able to perform.
- Only when Technical charges are billed by a BJC Facility will the BJC Facility level of copayment apply.

Providers

Signature (EPO) Providers

The Signature medical option utilizes Cigna's LocalPlus Network. The LocalPlus Network plan delivers a cost-effective solution designed to be flexible and help you control health care costs, without sacrificing the quality and convenience you want and expect.

Under this option, you must receive care from a health care professional or facility in the Cigna LocalPlus network to receive coverage.

If you're temporarily away from your local area, or in another Cigna LocalPlus Network area, you have extra peace of mind knowing you can access in-network providers or hospitals through our nationwide Away From Home Care feature, which provides nationwide coverage at in-network cost.

If you choose to go outside the LocalPlus Network when one is available (or outside the Away From Home Care feature when LocalPlus isn't available), your care will not be covered by the plan (except in an emergency). You will be responsible for the total cost of the services.

If you are unable to locate an In-Network Provider in your area who can provide you with a service or supply that is covered under this plan, you must call the number on the back of your I.D. card to obtain authorization for Out-of-Network Provider coverage. If you obtain authorization for services provided by an Out-of-Network Provider, benefits for those services will be covered at the In-Network benefit level.

Choice Plus and Choice (PPO) Providers

The BJC Choice Plus and BJC Choice medical coverage options each offer three (3) tiers of providers from which you can choose: BJC Facility, Network and Out-of-Network. These providers are the same regardless of the medical option you choose and are described below. Regardless of which provider you choose, in some instances, he or she may suggest a course of treatment that is not a covered service. If you proceed with a treatment that is not a covered service, the entire cost of the non-covered service will be your responsibility. Please read this SPD and/or contact the Benefits Manager if you question whether a service is covered.

BJC Facility Providers (PPO Options)

The Plan pays the highest level of benefits for services you receive from a BJC Facility. The facilities considered "BJC Facilities" are listed in the *Glossary of Medical Terms* section and may be updated from time to time. Please see the "BJC Facilities" columns of the *Schedule of Benefits – BJC Medical Plan Options* pages of this SPD to find the member out-of-pocket cost differences between BJC Facilities, Network providers and Out-of-Network providers.

Some services cannot be provided by a BJC Facility. In such cases, the applicable network or out-of-network copayment or coinsurance will apply, depending upon the provider you choose. Physician office visits are covered at the network or out-of-network level, not at the BJC Facility level.

Cigna Open Access Plus (OAP) Network Providers (PPO Options)

Certain providers of health care services have agreed to provide their services to Plan participants under terms that reduce costs for both you and your employer. These are labeled as "Cigna Network OAP Providers" on the *Schedule of Benefits – BJC Choice Plus/BJC Choice Medical Plan Options* pages. For Network providers, the deductible and coinsurance or copayment is lower than if you use an Out-of-Network provider.

Be sure to review the online provider directory at mycigna.com or contact Cigna at 800-244-6224 each time you visit a physician. When making appointments and seeking medical care you should confirm that the health care provider is still a participating provider with the Cigna OAP Network for BJC. If you desire to receive the highest level of benefits for services received from BJC Facilities, you also should make sure that your physician has admitting privileges at a BJC Facility.

For Telehealth services, you must pre-register through one of Cigna's Telehealth Connection providers. Please refer to the *Telehealth Services* section for details.

You are not required to elect a Primary Care Physician (PCP). If you receive medical care from a physician or other provider who is not part of the Cigna OAP Network, you will have to meet the applicable deductible and pay the higher Out-of-Network copayment or coinsurance for such care (except as described in the *Covered Medical Services* section).

Cigna Behavioral Health (PPO Options)

Cigna administers and manages the BJC medical plan's mental health and substance abuse treatment network. Please contact Cigna Behavioral Health (Cigna BH) by calling the toll-free number shown on your ID card to obtain the necessary prior authorization. If you do not receive services from an approved Cigna BH Network provider for mental health and substance abuse treatment, you may be responsible for payment at the higher Out-of-Network level.

Out-of-Network Providers (PPO Options)

You may choose to use a health care provider who is not a member of the BJC Facility, Cigna OAP, or Cigna BH Network, but this will increase your out-of-pocket costs. The Plan does not pay as much of the amount charged by an Out-of-Network provider. Generally, after you satisfy any applicable deductible, the Plan will pay 25%-50% of the reasonable and customary charges for covered services performed by an Out-of-Network provider. The percentage the Plan pays depends on which medical plan option you elected. You are responsible for the remaining charges above the percentage the Plan pays of the reasonable and customary charges for covered services performed by an Out-of-Network provider. Charges above reasonable and customary are your responsibility and will not apply to the deductible or the out-of-pocket maximum.

If the applicable Benefits Manager determines that there are no providers in the Network with appropriate training and experience to meet your particular health care needs, you may be referred to an Out-of-Network provider pursuant to a treatment plan approved by you, the applicable Benefits Manager and the Out-of-Network provider. In this case, you will only be required to pay the applicable deductible and copayment/coinsurance that you would pay if the services were rendered by a Network provider.

Claims for Benefits (PPO Options)

You do not have to file a claim for benefits if you use a Participating Provider (i.e., BJC Facility or Network provider). However, if you receive services from an Out-of-Network provider, you will be responsible for submitting claims to the applicable Benefits Manager. Please see the section of this SPD entitled *Claims Appeal Procedures – Medical/Pharmacy/Dental*. All claims for services received by an Out-of-Network provider must be submitted for reimbursement within twelve (12) months after the date the services were rendered in order to be eligible for coverage.

Deductibles, Copayments, Coinsurance and Maximums

Annual Deductibles

You must pay an annual deductible before certain services will be covered under the Plan. The deductible varies depending on the medical option you elect and the type of provider you choose (e.g., for Choice Plus and Choice - whether the provider is a BJC Facility, a Network provider or an Out-of-Network provider; the deductible is highest for Out-of-Network providers). Signature plan members must use providers in the Cigna LocalPlus network in order to receive coverage; there is no coverage for Out-of-Network providers. Please see the *Schedule of Benefits – BJC Medical Plan Options* section in this SPD for additional information. Please note the following features:

- The deductible applies to each covered individual each Plan Year.
- For the PPO options, the deductible for an in-network category of provider (BJC Facility and Network) can be satisfied with a combination of charges by the two (2) categories of providers.
- No more than three (3) times the individual deductible amount needs to be satisfied in any given Plan Year for all of your covered family members combined.
- This annual deductible only applies to services that require a percentage coinsurance payment and does not apply to services requiring a flat dollar copayment. This means that until the annual deductible is met, you pay the full amount for any covered service with a percentage coinsurance. After you meet the deductible, the Plan will pay the cost of covered services after any applicable coinsurance payment.

- For services that require a flat dollar copayment and a coinsurance after deductible, the flat dollar copayment will apply first, then the deductible and then the applicable coinsurance. Once the annual deductible is met, then the flat dollar copayment and coinsurance will apply.

The annual deductible does not apply to services that have a flat dollar copayment (e.g., physician office visits, emergency room, urgent care, necessary ambulance transportation). Therefore, flat dollar copayment amounts that you pay for these types of services do not count toward your annual deductible requirement. After you have paid the flat dollar copayment, the Plan will pay 100% for those covered medical services that do not require a coinsurance, regardless of whether the annual deductible is met. Laboratory and/or radiology services are subject to the applicable deductible and coinsurance, except for those that are performed as part of a medical office visit or a preventive care office visit at a BJC Facility or Network provider as described in the *Covered Medical Services* section.

Flat Dollar Copayments (Copayments)

For many types of expenses, you pay a fixed flat dollar amount at the time the services are rendered. The flat dollar amount you pay is called a copayment. The copayment required under each medical plan option is described further in the *Schedule of Benefits – BJC Medical Plan Options* table of this SPD.

Generally, the Plan pays for covered expenses after you pay the copayment that applies to the medical plan option in which you are enrolled.

Please note the following: For non-wellness/non-preventive care office visits, you will pay the applicable flat dollar copayment for BJC or other Network physicians, or the deductible and the 50%-75% coinsurance for Out-of-Network providers (see the *Percentage Coinsurance* section below). The coinsurance depends on which medical plan option you elected.

- For emergency services, you will pay a $250 or $300 copayment for treatment in any emergency room, for emergency services received at a BJC Facility (PPO options only), Network facility or Out-of-Network facility. The copayment depends on which medical plan option you elected.
- For urgent care, you will pay a $50 or $60 copayment for care at an urgent care facility. The copayment depends on which medical plan option you elected. The Plan pays 100% of the covered expenses after the copayment. This copayment is waived by the Plan if you are admitted to a hospital for treatment directly from the urgent care facility or emergency room at which you received treatment. The copayment you make for these services does not apply to the annual deductible requirement.
- If you receive services at a non-BJC facility, you will be responsible for the applicable Network or Out-of-Network copayment. This applies even if you tried to use a BJC Facility but could not due to circumstances beyond your control (e.g., the ambulance is diverted, beds are full, etc.).
- If you use a BJC Facility or Network facility, all professional services eligible for coverage will be payable at the Network provider level of coverage. If an Out-of-Network provider renders professional services as part of your treatment at a Network facility and you receive an invoice for those services beyond any applicable deductible or copayment, please contact the Benefits Manager.

Percentage Coinsurance (Coinsurance)

For most physician professional fees and hospital charges, you pay a percentage of charges at the time the services are rendered, after you have met the deductible as described above. The percentage you pay is called coinsurance. The required coinsurance under each medical plan option is described in the *Schedule of Benefits - BJC Medical Plan Options* table. If the annual deductible requirement applies to the particular service (the covered service requires a percentage coinsurance instead of a flat dollar copayment), the Plan will pay expenses for that covered service only after the annual deductible and coinsurance are met.

Please note the following:

- For wellness/preventive care office visits, you will pay the applicable deductible and percentage coinsurance if you use an Out-of-Network provider. Laboratory or radiology services received in connection with a wellness/preventive care office visit will be covered at 100% if the services are received at a BJC Facility or Network facility. If the services are received at an Out-of-Network facility, the Out-of-Network deductible and percentage coinsurance will apply.

- For non-wellness/non-preventive care office visits, you will pay the applicable flat dollar copayment for BJC or other Network physicians (see the *Flat Dollar Copayments* section above), or the deductible and the 50%-75% coinsurance for Out-of-Network providers. If you use a BJC or other Network physician, laboratory services that are billed as part of the Network physician's office visit will be covered at 100%. Laboratory services that are rendered and billed by a separate provider will be subject to the applicable deductible and the percentage coinsurance.
- All radiology services associated with a non-wellness/non-preventive care office visit, whether rendered or billed by a BJC or other Network physician or some other Network provider, will be subject to the applicable deductible, if any, and the applicable percentage coinsurance.
- If you receive services at a non-BJC facility, you will be responsible for the applicable Network or Out-of-Network coinsurance, even if you wanted to use a BJC Facility but could not due to circumstances beyond your control (e.g., the ambulance is diverted, beds are full, etc.).
- If you use a BJC Facility or Network facility, all professional services eligible for coverage will be payable at the Network provider level of coverage. If an Out-of-Network provider renders professional services as part of your treatment at a Network facility and you receive an invoice for those services beyond any applicable deductible or copayment, please contact the Benefits Manager.

Annual Out-of-Pocket Maximum

The annual out-of-pocket maximum provides additional protection for you by putting a cap on what you pay in one Plan Year for covered expenses. Once your deductible, flat dollar copayments and percentage coinsurance (which coinsurance is payable after the deductible) during the Plan Year reach the out-of-pocket maximum that applies to a particular category of provider, you will not be required to pay any additional copayments or coinsurance for services in that category for the remainder of the Plan Year. The Plan will pay 100% of your expenses incurred in that category. The maximum amount you must pay depends on the medical plan option in which you are enrolled and whether you receive your care from BJC Facilities, Network providers or Out-of-Network providers. The out-of-pocket maximum under each medical plan option is described in the *Schedule of Benefits – BJC Medical Plan Options* table.

Please note the following features:

- The out-of-pocket maximum applies to each covered individual each Plan Year. The family out-of-pocket maximum is no more than three (3) times the individual maximum.
- The out-of-pocket maximum for an in-network category of provider (BJC Facility and Network) can be satisfied with a combination of charges by the two (2) categories of providers.
- When family members incur any combination of covered charges that are counted toward the family out-of-pocket maximum in any Plan Year (as long as no one person exceeds his or her individual amount), the annual out-of-pocket maximum is considered met for your entire family.

Charges that do not count toward the annual out-of-pocket maximum include premiums/contribution amounts, ineligible charges (including charges by an Out-of-Network provider above usual and customary charges, or services that are excluded from coverage under the Plan), ineligible charges that exceed the lifetime maximum for a specific service (e.g. Fertility Services), and reductions in benefits caused by failure to comply with the utilization review procedures or charges in excess of Plan maximums.

Services Requiring Prior Authorization

Services Requiring Prior Authorization from the Benefits Manager

It is the Network provider's responsibility (for network services) or the patient's responsibility (for out-of-network services) to ensure proper prior authorization (precertification) is obtained for the following services:

- All inpatient services, including hospital admissions, services received on an inpatient basis from a skilled nursing facility or hospice program, or inpatient admissions for mental health or substance abuse treatment.
- Inpatient and Outpatient Bariatric Surgery, subject to eligibility requirements.

- Inpatient and Outpatient Spinal Arthroplasty, Cervical and/or Lumbar spinal fusion procedures and artificial, advanced, or total disc replacements or lumbar nuclear disc replacements.
- Maternity care stays beyond those described in the later section entitled *Length of Hospital Stay for Delivery of a Newborn* must be authorized in advance by the Benefits Manager to be covered. In addition, the Benefits Manager should be notified of a pregnancy, so participants can take advantage of the Benefits Manager's maternity management program, if applicable.
- Outpatient services (e.g. outpatient surgery, high-tech radiology (MRI, CAT scans, PET scans, nuclear cardiology), durable medical equipment (DME), home health care/home infusion therapy, dialysis, external prosthesis devices, sleep management, transplants, radiation therapy).
- Anesthesia and hospital charges for certain dental services covered under the medical Plan as described later in this SPD.

For prior authorization of non-mental health services, contact the Benefits Manager. For prior authorization of Mental Health or Substance Abuse Services, contact Cigna Behavioral Health by calling the toll-free number on your ID card.

IF YOU DO NOT OBTAIN PRIOR AUTHORIZATION (PRECERTIFICATION) FOR OUT-OF-NETWORK SERVICES, YOU ARE RESPONSIBLE FOR PAYING 100% OF THE COST OF THE FACILITY SERVICES PROVIDED.

Initial Determination by the Benefits Manager

Generally, the Benefits Manager will make a determination within fifteen (15) days of receiving a request for prior authorization. An extension may be requested if more information is necessary, and the timeframe is shorter if the request qualifies as an urgent care claim. Please see the subsection entitled *Initial Claims Determinations in the Claims Appeal Procedures – Medical/Pharmacy/Dental* section of this SPD for more information on pre-service claims.

Concurrent Review Determinations

If review is necessary while you are receiving services, the Benefits Manager will make a determination within one (1) working day of obtaining necessary information.

- If the service is certified, the Benefits Manager will notify your health care provider by telephone within one (1) working day. Written/electronic confirmation will be provided to you and your health care provider within one (1) working day of the telephone notice.
- If the service is not certified, the Benefits Manager will notify your health care provider by telephone within twenty-four (24) hours. Written/electronic confirmation to you and your health care provider shall be provided within one (1) working day of the telephone notice. Services will be continued without additional liability to you, except the applicable copayment or any deductible, until you have been notified that the service is no longer certified. If you choose to continue to receive care from a provider after notification that the services will not be covered, you will be responsible for the full cost of such services and such amount will not apply to any deductible or out-of-pocket maximum.

Retrospective Review Determinations

In some instances, it may be impossible for the Benefits Manager to certify a service before the service is provided.

The Benefits Manager will make a determination whether to certify a service on a retrospective basis within thirty (30) days after receiving a request.

Services may not be covered if you or your provider fails to provide the Benefits Manager with requested information.

Covered Medical Services

Covered medical services under the Plan are listed here and must meet the applicable medical necessity criteria according to the Plan. Some of these services have special rules or limits as described below. Deductibles, copayments and/or coinsurance, if any, will apply to services rendered.

Alcoholism and Substance Abuse

Please refer to the *Mental Health and Substance Abuse Services* section below.

Allergy Testing

Allergy testing is covered for evaluations and injections, other than the testing methods described in *Medical Exclusions* section (not including serum costs, which are covered under the *Pharmacy Program*). Injections received in the physician's office, without an office visit, will be covered at 100% without a copayment. The applicable physician office visit copayment will apply for allergy testing or injections associated with an office visit.

Ambulatory/Outpatient Surgery

Outpatient services and supplies furnished by an ambulatory surgery center in connection with a surgical procedure on the day of the procedure.

Ambulance Services

The Plan covers ambulance transportation by standard-equipped ground or air ambulance vehicles regularly performing ambulance service as follows:

- In the case of an emergency medical condition, emergency surface ambulance transportation to the nearest hospital where emergency services and treatment can be rendered is covered, if provided by a licensed ambulance service.
- Non-emergency surface ambulance transportation is covered for a member to be transferred from an Out-of-Network provider to a Network provider when medically appropriate to do so.
- Ground or air ambulance transportation is covered only when medically necessary.

- Ambulance transportation provided due to the unavailability of other forms of transportation is not covered.

Autism Spectrum Disorders Treatment

Autism Spectrum Disorders are defined as neurological disorders, usually appearing in the first three (3) years of life that affect normal brain functions and are typically manifested by impairments in communication and social interaction, as well as restrictive, repetitive, and stereotyped behaviors.

For an autism diagnosis, coverage for short-term rehabilitation services for physical therapy, aquatic therapy, occupational therapy, and speech therapy received on an outpatient basis are covered. The services must be directed and monitored by a physician. There is no limit on the number of days of outpatient rehabilitation therapy in a Plan Year. Group therapy for autism is not a covered service.

Please also refer to the section *Rehabilitation Therapy.*

Bariatric Surgery

Certain bariatric surgeries are covered under the Plan. Coverage is subject to the rules listed below.

- Patient must have been enrolled in the Plan (BJC Choice Plus or BJC Choice option) for at least one (1) year.
- Patient must be between the ages of 18-65

- Prior Authorization by the Benefits Manager required for all inpatient and outpatient bariatric surgeries.
- Covered as any other surgery, with applicable copayments and coinsurance
- Covered **only** at a BJC Facility (Barnes-Jewish Hospital, Parkland, Missouri Baptist, etc.). There will be no coverage at a Cigna Network provider or Out-of-Network provider.
- Must have BMI of 40 or greater, or:
- BMI of 35 or greater with at least one of the following co-morbidity conditions: cardiopulmonary problems, sleep apnea, hypertension, congestive heart failure, diabetes.
- Patient must be currently enrolled, and for at least six (6) months of the preceding twelve (12) months, in an organized, physician supervised weight loss program. This can mean enrollment in a commercially-recognized program such as Jenny Craig or Weight Watchers, as long as weight loss results are reported regularly to the treating physician and patient provides documentation that he/she has met the enrollment requirement of six (6) months.
- Patient must participate in a total assessment program, which includes behavioral, dietary, and psychological components and meetings with a physical therapist and surgeon. Attending physician (surgeon) must approve based on the results of this assessment. Any programs in the total assessment program that are not covered by the BJC Medical Plan will be paid 100% by the member.
- Only laparoscopic procedures will be covered, and only the following types of laparoscopic procedures will be covered: Roux-en-Y gastric bypass, adjustable gastric banding, and sleeve gastrectomy. No other procedures will be covered. In the event of a "medical emergency," appropriate services will be covered. Medical emergency in this instance is defined as a sudden and unexpected medical complication that, if not treated immediately, could result in a loss of life.
- Any pre-surgery services and supplies associated with a plan approved bariatric procedure will be covered once the bariatric procedure has been approved. These services include, but are not limited to: diagnostic labs, diagnostic x-rays, and diagnostic testing.
- Any post-surgery follow-up services and supplies associated with a plan approved bariatric procedure will be covered for a period of six (6) months from the date of the approved bariatric procedure. These services include, but are not limited to: routine follow-up visits, labs, and all medically necessary testing.

Revisional Bariatric Surgeries

- Covered **only** at a BJC Facility (Barnes-Jewish Hospital, Parkland, Missouri Baptist, etc.). There will be no coverage at a Cigna Network provider or Out-of-Network provider.
- A revisional bariatric surgery (any surgery following the initial procedure) will be covered only if complications arise as a result of the initial surgery.
- A revisional surgery will not be covered for weight regain or if the patient is unable to lose weight from the initial surgery regardless of when the original surgery was performed.
- Band adjustments are covered for up to two (2) years following gastric banding surgery and are covered only if the initial bariatric procedure took place on or after January 1, 2011. Band adjustments do not require prior authorization.

Breastfeeding Equipment and Supplies

Certain Breastfeeding Equipment and Supplies are covered 100% as preventive (requires a prescription and must be ordered through a BJC Pharmacy or EviCore through Cigna).

Covered breastfeeding equipment and supplies include:

- Purchase of a manual breast pump or a standard electric breast pump (E0603) as medically necessary for the initiation or continuation of breastfeeding. Purchase of a manual or standard electric breast pump is limited to one pump per birth and no sooner than one (1) week prior to the delivery/due date.
- Supplies (& applicable HCPCS (Billing) Codes) necessary for the use of a breast pump include:
  - Tubing for breast pump, replacement (A4281)

- Adapter for breast pump, replacement (A4282)
- Cap for breast pump bottle, replacement (A4283)
- Breast shield and splash protector for use with breast pump, replacement (A4284)
- Polycarbonate bottle for use with breast pump, replacement (A4285)
- Locking ring for breast pump, replacement (A4286)

- Rental of a heavy-duty electric/hospital grade breast pump as medically necessary for the initiation or continuation of breastfeeding and the purchase of necessary supplies.

Supplies for comfort and convenience are not covered and include, but are not limited to, the following: a nursing bra, nursing bustier (includes hands-free), bottles (except for Polycarbonate for use with breast pump, replacement), disks for bottle covers, cleaning supplies and accessories, car adaptors, ice packs, nursing stools, and storage.

Chiropractic Care Services

Charges made for diagnostic and treatment services provided in an office setting by Physicians providing chiropractic treatment. Chiropractic treatment includes the conservative management of acute neuromusculoskeletal conditions through manipulation and ancillary physiological treatment rendered to specific joints to restore motion, reduce pain, and improve function. For these services, you have direct access to Network qualified chiropractic Physicians.

Medical necessity must be established to the satisfaction of the Benefits Manager who will generally seek additional information after five (5) visits. Coverage for chiropractic treatment is limited to a maximum of twenty (20) visits per Plan year per member.

The following limitation applies to Chiropractic Care Services:

- occupational therapy is provided only for purposes of enabling persons to perform the activities of daily living after an Injury or Sickness.

Chiropractic Care services that are not covered include but are not limited to:

- services of a chiropractor which are not within his scope of practice, as defined by state law;
- charges for care not provided in an office setting;
- maintenance or preventive treatment consisting of routine, long term or non-medically necessary care provided to prevent recurrence or to maintain the patient's current status;
- vitamin therapy.

Clinical Trials

Coverage of ordinary and necessary care received while participating in a clinical trial is generally covered, subject to the coverage guidelines listed below.

As referred to in the "Clinical Trial Coverage Guidelines", the term "clinical trial" shall mean either a formal clinical trial, or a component of care that is considered experimental/investigational, because it is still being studied as part of a clinical trial. The Clinical Trial Coverage Guidelines are available by contacting the Benefits Manager.

Please refer to the "BJC HealthCare Medical Plan Provider Guide for Clinical Trials" for more specific information regarding Clinical Trial benefits, medical necessity provisions and coverage determinations. This guide is available by contacting the Benefits Manager.

Application to enrollees under the Plan:

The components of care rendered solely as a result of a clinical trial in which the individual is enrolled will continue to fall within the exclusion from coverage.

- All drugs and devices not approved by the FDA for any purpose will be excluded.

- The fact that an enrollee is being treated with an "off-label use" of a drug approved by the FDA for other purposes will not, by itself, automatically render all ordinary and necessary care that is provided to the enrollee to be labeled "experimental," and, therefore, not covered under the Plan.
- If an enrollee is admitted solely for the purpose of an experimental treatment rendered in connection with a clinical trial, the entire admission will be treated as excluded.

To the extent ordinary and necessary care is rendered during the same encounter as care rendered in connection with a clinical trial, or experimental/investigational component, as long as the ordinary and necessary care is not rendered solely as part of the clinical trial, the Plan will treat the ordinary or necessary care as a Covered Service (to the extent no other relevant provision of the Plan applies).

To the extent additional care is required solely as a result of the care rendered in connection with a clinical trial; such additional care will not be covered.

- For the purposes of determining whether additional care is required solely as a result of the clinical trial, a physician (with appropriate knowledge and training in the relevant area) must be able to reasonably conclude that, but for the care rendered in connection with the clinical trial, the additional care provided would not have been required. Notwithstanding the foregoing, care for complications that arise from care rendered as part of a clinical trial will be covered under the Plan.

Cosmetic, Plastic and Reconstructive Surgery

Cosmetic, plastic, and reconstructive surgery is covered if it is medically necessary and:

- The surgery is to repair a functional disorder caused by disease or injury, and the surgery is performed within six (6) months of such injury, or
- The surgery is medically necessary for the correction of a congenital anomaly of a covered dependent newborn child, or
- The surgery is post-mastectomy for breast reconstruction, including surgery on the unaffected breast to promote symmetry and surgically implanted breast prostheses (see details below under *Post Mastectomy Care*).

Dental Anesthesia and Hospital Services

Dental anesthesia and hospital charges for dental care provided to the following medical Plan members when authorized in advance by the Benefits Manager:

- An individual age seven (7) years or younger.
- An individual who is severely psychologically impaired or developmentally disabled.
- An individual with American Society of Anesthesiologists (ASA) Physical Status Classification of P3 or greater.
- An individual who has one or more significant medical comorbidities which:
  - preclude the use of either local anesthesia or conscious sedation, or
  - require careful monitoring during and immediately following the planned procedure.
- Individuals for whom conscious sedation would be inadequate or contraindicated for any of the following procedures:
  - removal of two or more impacted third molars.
  - removal or surgical exposure of one impacted maxillary canine.
  - surgical removal of two or more teeth involving more than one quadrant.
  - routine removal of six or more teeth.
  - full arch alveoplasty.
  - periodontal flap surgery involving more than one quadrant.
  - radical excision of tooth-related lesion greater than 1¼ cm or ½ inch.

- tooth-related radical resection or ostectomy with or without grafting.
- placement or removal of two or more dental implants.
- tooth transplantation or removal from maxillary sinus.
- extraction with bulbous root and/or unusual difficulty or complications noted.
- removal of exostosis involving two areas.
- removal of torus mandibularis involving two areas.

Diabetic Services and Supplies

Subject to payment of the applicable copayment or coinsurance, the following equipment, supplies and education services for the treatment of insulin-treated diabetes, non-insulin-treated diabetes, and gestational diabetes conditions are covered:

- Blood glucose monitors.
- Insulin pumps and pump supplies. (Insulin is covered under the *Pharmacy Program*.)
- Medically necessary diabetes self-management education. Coverage for self-management education and education relating to medical nutrition therapy also includes home visits when medically necessary. Group diabetic nutrition counseling is also covered.

Dietary Supplements or Formula

Dietary supplements or formula are covered if:

- Prescribed by a physician for the treatment of phenylketonuria (PKU), or
- They are the primary source of an individual's nutrition because of a medical condition.

Durable Medical Equipment (DME) and Prostheses

The purchase, repair, or rental of durable medical or surgical equipment is covered if medically necessary. The equipment is subject to prior authorization approval by the Benefits Manager if the device or special appliance is listed on the Benefit Manager's Prior Authorization list.

The initial purchase of such equipment and necessary accessories is covered only if long-term use is planned, and the equipment cannot be rented, or it is likely to cost less to buy it than to rent it. Repair or replacement of purchased equipment and accessories is covered only if it is needed due to a change in the covered individual's physical condition. The equipment will be repaired if it is likely to cost less to repair the existing equipment than to rent new equipment.

External prosthetic devices and special appliances are covered if they are to replace temporarily or permanently all or part of an internal body organ or external body organ, which is lost or impaired due to disease or injury. Coverage includes repair and replacement when due to normal growth or normal wear and tear of internal artificial organs.

Implantable insulin pumps are covered if medically necessary and authorized in advance.

One (1) wig is covered for hair loss as a result of undergoing chemotherapy for a cancer diagnosis. Coverage is limited to a Lifetime Maximum of one (1) wig per member.

Emergency Services and Urgent Care

For purposes of the Plan, the terms "emergency" and "medical emergency" mean the sudden and, at the time, unexpected onset of a health condition that requires immediate hospital treatment to avoid physical impairment, medical

complications, or loss of life. The Plan Administrator has the sole discretion to determine afterward if a medical emergency existed at the time medical services were received by a covered individual.

If you receive care for an emergency medical condition or urgent care services:

- You will pay a $150 copayment if enrolled in the BJC Choice Plus option, a $200 copayment if enrolled in the BJC Choice option, or a $250 copayment if enrolled in the Signature option, for emergency room charges and a lower copayment (varies by plan option) for urgent care facility charges. These charges are waived if you are admitted to a hospital for treatment directly from the emergency room or urgent care facility.
- If admitted to the hospital in an emergency, you or the health care provider should call the Benefits Manager within forty-eight (48) hours (excluding weekends) after the date your confinement begins. You will not receive coverage for follow-up care unless you contact the Benefits Manager within forty-eight (48) hours. If it is not physically possible for you to contact the Benefits Manager within forty-eight (48) hours, you should contact the Benefits Manager as soon as it is reasonably possible for you to do so.
- The Plan will pay for all covered services and supplies for emergency or urgent care treatment after the applicable copayment.

Use of urgent care centers, emergency rooms or freestanding emergency facilities for routine (non-emergency or non-urgent care services) care is generally NOT covered. However, if you have a true emergency medical condition, you should seek medical care at the nearest facility for treatment.

If you are admitted to an Out-of-Network facility for care following an emergency, you will only be responsible for the applicable deductible and network copayment that you would have paid if you were using a Network facility, until such time as the Benefits Manager determines that it is appropriate for you to be transferred to a Network provider (as long as the Benefits Manager is notified within forty-eight (48) hours, or as soon as medically possible, of the admission as described above). If you are notified by the Benefits Manager that you may be transferred to a Network provider and you choose to continue to receive services at an Out-of-Network provider, you will be responsible for the Out-of-Network deductible and copayment level for services received after you are so notified.

If you used an Out-of-Network provider for emergency or urgent care services due to circumstances that prevented you from using a Network provider, and you receive an invoice from the Out-of-Network provider for services beyond any applicable deductible or copayments, please contact the Benefits Manager.

Follow-up Care

The Plan covers any follow-up care that you receive after an emergency medical condition or urgent care situation has ended, subject to the applicable plan deductible or copayment. All follow-up care must be provided by a Network provider in order to be covered at the network level of copayment.

Family Planning Services

The following family planning services are covered:

- Diagnostic, counseling, and planning services for treatment of the underlying cause of infertility. Diagnostic procedures are limited to sperm count, endometrial biopsy, hysterosalpingography and diagnostic laparoscopy.
- The measurement and fitting of contraceptive devices.
- Advice on contraception and family planning.
- Fertility services, including lab and radiology test, counseling, surgical treatment, artificial insemination, in-vitro fertilization, etc. (see details below under *Fertility Services)*.

Fertility Services

Coverage for services necessary for the diagnosis of and treatment of infertility once a condition of infertility has been diagnosed or for the purposes of preimplantation genetic testing when the member or couple meet the approval criteria for preimplantation genetic diagnostic testing (PGD).

Coverage will be provided for the following services:

- Testing and treatment services performed in connection with an underlying medical condition.
- Testing performed specifically to determine the cause of infertility.
- Treatment and/or procedures performed specifically to restore fertility (e.g. procedures to correct an infertility condition).
- Artificial insemination, in-vitro fertilization, etc.

Coverage is limited to a medical Plan lifetime maximum of $7,500 per member (additional $2,500 lifetime maximum under the *Pharmacy Program*). Charges that exceed this lifetime maximum are not covered by the Plan, are excluded from the annual out-of-pocket maximum and are 100% the responsibility of the member.

Services include, but are not limited to: fertility drugs which are administered or provided by a Physician; approved surgeries and other therapeutic procedures that have been demonstrated in existing peer-reviewed, evidence-based, scientific literature to have a reasonable likelihood of resulting in pregnancy; laboratory tests; sperm washing or preparation; artificial insemination; diagnostic evaluations; in vitro fertilization (IVF); and the services of an embryologist.

Infertility is defined as the inability to achieve conception after one year of unprotected intercourse; or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

However, the following are specifically excluded fertility services:

- reversal of male and female voluntary sterilization;
- fertility services when the infertility is caused by or related to voluntary sterilization;
- donor charges and services;
- cryopreservation of donor sperm and eggs; and
- any experimental, investigational, or unproven fertility procedures or therapies.

Gender Dysphoria Services

The Plan covers psychotherapy for gender dysphoria (and other associated psych diagnoses) and hormone therapy (includes lab testing to monitor the hormone therapy).

Gender reassignment/transsexual surgery and related services are covered, subject to pre-authorization.

Certain hormone therapy drugs are covered under the *Pharmacy Program*.

Home Health

The Plan covers services and supplies furnished in the home by a home health care agency or licensed health professional, including, but not limited to: registered nurses, licensed practical nurses, physical therapists, respiratory therapists, speech therapists and home health aides is limited to one hundred twenty (120) days per Plan year. Each visit by a nurse or therapist is one (1) visit, and each visit of up to four (4) hours by a home health aide is one (1) visit. The maximum number of home health visits will be reduced by any visits received at home by a therapist for speech, physical or occupational therapy.

Hospice Care

The Plan covers care provided as a part of a hospice program for a covered individual in the home or who is confined as an inpatient in a hospital, skilled nursing facility or hospice facility. Coverage includes supportive care involving the evaluation of the emotional, social, and environmental circumstances related to or resulting from a covered individual's illness. It also includes guidance and assistance given during the covered individual's illness for the purpose of preparing the covered individual and the covered individual's immediate family for imminent death. The covered individual must have a prognosis of six (6) months or less to live.

For hospice care purposes, the definition of "family" is limited to the covered individual's parents, spouse, children, and, in the case of a covered child who is terminally ill, the child's siblings, regardless of whether they are covered individuals. Coverage is not provided for bereavement counseling, funeral arrangements, pastoral counseling, financial or legal counseling, homemaker or caretaker services (services that are not solely related to the care of the person, including, but not limited to: sitter or companion services for the covered individual who is ill or other members of the family, transportation, housecleaning and maintenance of the house), and respite care (care furnished during a period of time when the covered individual's family or usual caretaker cannot, or will not, attend to the covered individual's needs).

Hospital Care

Hospital care (excluding alcoholism, Substance Abuse and Mental Health services, which are covered as described separately under *Alcoholism and Substance Abuse* and *Mental Health and Substance Abuse Services*) is covered as follows:

- Inpatient care: Hospital inpatient services and supplies including professional services, semiprivate room and board or private room and board if the Benefits Manager determines it to be medically necessary, general nursing care, and related services and supplies. All inpatient services require prior authorization from the Benefits Manager.
- Outpatient care: Hospital outpatient services and supplies including professional services, semiprivate room and board or private room and board if the Benefits Manager determines it to be medically necessary. All outpatient services (e.g. outpatient surgery, high-tech radiology (MRI, CAT scans, PET scans, nuclear cardiology), durable medical equipment (DME), home health care/home infusion therapy, dialysis, external prosthesis devices, sleep management, transplants, radiation therapy) require prior authorization from the Benefits Manager. Outpatient Spinal Arthroplasty, Cervical and/or Lumbar spinal fusion procedures and artificial, advanced, or total disc replacements or lumbar nuclear disc replacements also require prior authorization from the Benefits Manager.

Laboratory Services

Laboratory tests ordered in conjunction with wellness and preventive care visits are covered. If such services are not diagnostic but received at a BJC Facility or Network facility, the Plan will pay 100% after the office visit copayment. If the laboratory test is diagnostic and received at a BJC Facility, the Plan will pay 100%. If the laboratory test is diagnostic (not associated with a preventive visit), it will be covered at 100% for the following services, if provided at a Network facility: colonoscopy, mammogram, PSA test, cholesterol, cervical cancer screening, colon cancer screening, blood sugar, blood pressure. If services are received at an Out-of-Network facility, the applicable deductible and coinsurance will apply.

Maternity Care

The Plan covers the following services and supplies furnished by a physician or hospital (including a birthing center other than for complications) to you or your covered spouse:

- Prenatal care (including related genetic testing).
- Delivery.
- Postnatal care (but only within twenty-four (24) hours after delivery if care is provided by a birthing center).
- Care for the complications of pregnancy.

The Plan does not cover the pregnancy of any dependent child, other than medical complications when treatment is needed to protect the life of the mother and certain wellness/preventive screenings recommended during pregnancy and required by law. (A cesarean section is not considered a complication.) Although treatment for the mother in a life-threatening situation will be covered, charges incurred for the newborn of the dependent will not be covered.

Length of Hospital Stay for Delivery of Newborn

Under federal law, a mother and her covered newborn child are entitled to the following minimum hospital stays:

- A minimum of forty-eight (48) hours of inpatient care in a hospital following a vaginal delivery.
- A minimum of ninety-six (96) hours of inpatient care in a hospital following a cesarean section.

However, federal law does not prohibit a mother from being discharged prior to the end of these minimum periods if the mother requests an early discharge and the discharge is determined to be medically appropriate by the providers in consultation with the mother and in accordance with the most current version of the "Guidelines for Perinatal Care" prepared by the American Academy of Pediatrics and the American College of Obstetricians and Gynecologists. A mother who requests a shorter hospital stay will be covered for a minimum of two post-discharge visits. The post-discharge visits will be conducted by a registered professional nurse with experience in maternal and child health nursing and shall be in accordance with the most current version of the "Guidelines for Perinatal Care." This at-home visit after a delivery does not count toward the annual limit on the number of home health care visits and no additional copayment will apply.

Maternity care stays beyond the above described minimum require prior authorization in advance by the Benefits Manager to be covered. In addition, the Benefits Manager should be notified of a pregnancy, so participants can take advantage of the Benefits Manager's maternity management program, if applicable.

See also *Newborn Coverage* below.

Mental Health and Substance Abuse Services

The Plan provides coverage for the following Inpatient and Outpatient Mental Health Services and for the following Inpatient and Outpatient Substance Abuse Rehabilitation Services.

Inpatient Mental Health Services

Services that are provided by a Hospital while the covered individual is confined in a Hospital for the treatment and evaluation of Mental Health. Inpatient Mental Health Services include Partial Hospitalization sessions. Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in any 24-hour period.

Inpatient Mental Health Services also include Mental Health Residential Treatment Services. Mental Health Residential Treatment Services are services provided by a Hospital or Mental Health Residential Treatment Center for the evaluation and treatment of the psychological and social functional disturbances that are a result of subacute Mental Health conditions. A person is considered confined in a Mental Health Residential Treatment Center when she/he is a registered bed patient in a Mental Health Residential Treatment Center upon the recommendation of a Physician.

Outpatient Mental Health Services

Services of Providers who are qualified to treat Mental Health when treatment is provided on an outpatient basis, while the covered individual is not confined in a Hospital, and is provided in an individual, group or Mental Health Intensive Outpatient Therapy Program.

Covered services include, but are not limited to, outpatient treatment of conditions such as: anxiety or depression which interfere with daily functioning; emotional adjustment or concerns related to chronic conditions, such as psychosis or depression; emotional reactions associated with marital problems or divorce; child/adolescent problems of conduct or poor impulse control; affective disorders; suicidal or homicidal threats or acts; eating disorders; acute exacerbation of chronic Mental Health conditions (crisis intervention and relapse prevention) and outpatient testing and assessment; and Applied Behavioral Analysis (ABA) related to the treatment of autism spectrum disorders (including Autistic Disorder, Asperger's Disorder, Pervasive Developmental Disorder not otherwise specified, Rett's Disorder and Childhood Disintegrative Disorder).

A Mental Health Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Mental Health program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Inpatient Substance Abuse Rehabilitation Services

Services provided for rehabilitation, while the covered individual is confined in a Hospital, when required for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs. Inpatient Substance Abuse Services include Partial Hospitalization sessions. Partial Hospitalization sessions are services that are provided for not less than four (4) hours and not more than twelve (12) hours in any 24-hour period.

Inpatient Substance Abuse Services also include Substance Abuse Residential Treatment Services. Substance Abuse Residential Treatment Services are services provided by a Hospital or Substance Abuse Residential Treatment Center for evaluation and treatment. A person is considered confined in a Substance Abuse Residential Treatment Center when she/he is a registered bed patient upon the recommendation of a Physician.

Outpatient Substance Abuse Rehabilitation Services

Services provided for the diagnosis and treatment of abuse or addiction to alcohol and/or drugs, while the covered individual is not confined in a Hospital, including outpatient rehabilitation in an individual, a group, or a Substance Abuse Intensive Outpatient Therapy Program.

A Substance Abuse Intensive Outpatient Therapy Program consists of distinct levels or phases of treatment that are provided by a certified/licensed Substance Abuse program. Intensive Outpatient Therapy Programs provide a combination of individual, family and/or group therapy in a day, totaling nine (9) or more hours in a week.

Substance Abuse Detoxification Services

Detoxification and related medical ancillary services are covered when required for the diagnosis and treatment of addiction to alcohol and/or drugs. Cigna Behavioral Health will determine, based on the **Medical Necessity** of each situation, whether such services will be covered in an inpatient or outpatient setting.

Newborn Coverage

In order for your newborn to be covered under the Plan from birth, you must submit your enrollment paperwork to add the child as a dependent within sixty (60) days of birth. See *Newborn or Newly Adopted Child Eligibility* under the *Dependent Eligibility* section of this SPD.

Services and supplies are covered for the treatment of disease or injury of a newborn child when medically necessary, including care for the treatment of congenital defects and birth abnormalities, which cause anatomical functional impairment. Inter-facility transfer of the newborn to the nearest appropriate facility to treat the newborn's condition will be covered. Applicable deductibles and copayments, if any, will apply.

Nutrition Counseling Services

Nutrition counseling is covered when performed by a provider who is licensed or certified to provide nutrition counseling in the state where he/she practices. This benefit is covered 100% when received from BJC or Network providers, up to $1,000 per Plan Year per member. Once a member reaches $1,000, applicable copayments and deductibles apply. Services are subject to deductible and applicable coinsurance when performed by an Out-of-Network provider. Group nutrition counseling is not a covered service, except diabetic nutrition counseling as part of *Wellness/Preventive Care.*

Oral Surgery

Oral surgery services covered under the Plan are:

- Excision of tumors and cysts of the bone, except those associated with endodontic surgery.
- Treatment of head and neck cellulitis, and treatment of diseases of salivary glands and ducts.
- Extraction of teeth that are in the port of radiation therapy.

- Treatment of accidental trauma to sound, natural teeth provided within forty-eight (48) hours of such trauma.
- Oral surgery required to correct accidental injuries of the jaw, cheeks, lips, tongue, roof, and floor of the mouth.
- Diagnosis and surgical correction of temporomandibular joint disease for conditions such as cancer, arthritis and complications arising from injuries to the jaw joint subject to approval by the Benefits Manager. Treatment of temporomandibular joint syndrome in the absence of actual disease of the jaw joint is not covered.
- Treatment of complete bony impaction of teeth is eligible for coverage through the medical benefit if the employee is not enrolled in a BJC HealthCare dental option under the Plan at the time of service and the treatment is medically necessary as determined by the Benefits Manager.

Physician Services

The Plan covers services furnished by a physician during an office visit, hospital visit, or house call for the diagnosis and treatment of a disease or injury. Copayments, coinsurances, and deductibles, if any, will apply.

Post-Mastectomy Care

As required by the Women's Health and Cancer Rights Act of 1998, the Plan provides certain benefits for mastectomy-related services.

If you or your covered dependents have a mastectomy, the Plan will cover, in a manner determined in consultation with the attending physician and the patient, all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the unaffected breast to produce a symmetrical appearance and prostheses and treatment of physical complications of the mastectomy, including lymphedema. Prosthetic devices and reconstructive surgery shall have the same deductible and copayment as any other similar service under the Plan. In other words, the applicable deductible, if any, and the copayment for a reconstructive surgery and treatment would be the same as would apply to any other type of surgery under the Plan and prosthetic devices would be covered just as any other prosthetic devices are covered under the Plan. Please contact the Benefits Manager for more information regarding these benefits.

Prescription Drugs

Prescription drugs are generally covered under the *Pharmacy Program* (please refer to the *Pharmacy Program* section for more details). However, certain drugs are covered under the medical portion of the Plan as follows:

- Certain outpatient Medicare Part B drugs are covered, as determined from time to time by the Plan, where Medicare is the primary carrier of the coverage for an individual and the Plan provides secondary coverage.
- Medications are covered if administered or infused in a physician's office. This does not include injectable drugs which are considered to be self-administered and are covered under the *Pharmacy Program*.

Preventive Care

See *Wellness/Preventive Care* below.

Radiology Services

X-rays ordered in conjunction with wellness and preventive care visits are covered. Diagnostic and therapeutic radiology (radiation therapy) services and laboratory tests furnished on an outpatient basis; if such services are received at a BJC Facility, the Plan will cover 100%, including applicable physicians' charges, or, if received at a Network facility, the applicable copayments, coinsurances and deductibles, if any, will apply.

Rehabilitation Services

Rehabilitation services are covered as listed below. Except as noted below, copayments, coinsurances, and deductibles, if any, will apply.

- Short-term rehabilitation services for physical therapy, aquatic therapy, occupational therapy and speech therapy received on an inpatient or outpatient basis are covered if medically necessary (excluding coverage for autism – see below) and if services are expected to result in significant functional improvement within sixty (60) days from the date therapy begins. The services must be directed and monitored by a physician. There is no limit on the number of days of inpatient or outpatient rehabilitation therapy in a Plan Year. The Plan will cover 100% of such outpatient short-term rehabilitation services if received at a BJC Facility.
- Short-term rehabilitation services for physical therapy, aquatic therapy, occupational therapy, and speech therapy coverage for autism received on an outpatient basis are covered. The services must be directed and monitored by a physician. There is no limit on the number of days of outpatient rehabilitation therapy in a Plan Year. The Plan will cover 100% of such outpatient short-term rehabilitation services for autism if received at a BJC Facility. Group therapy for autism is not a covered service. Please also refer to the section *Autism Spectrum Disorders Treatment.*
- Outpatient cardiac rehabilitation services are covered.
- Outpatient pulmonary rehabilitation services are covered.
- Group rehabilitation is not a covered service.

Second Opinions

You may obtain a second opinion from another physician if you have received an initial diagnosis which requires major surgery or other treatment that requires general anesthesia or if you are diagnosed with a serious illness involving loss of a bodily part or function or other debilitating disease. This opinion will be at no additional cost to you beyond the applicable copayment that you would otherwise pay for an initial medical opinion or consultation from such provider. If there are no Network providers with the expertise necessary to provide a second medical opinion, the Benefits Manager will arrange for a referral to a physician with the necessary expertise. In that case, you will incur no additional cost beyond the applicable copayment that you would have otherwise paid if the services were rendered by a Network physician. If, however, you choose an Out-of-Network provider when a Network provider is available, you will be responsible for the applicable deductible and Out-of-Network copayment/coinsurance level.

Skilled Nursing

Care and treatment at a skilled nursing facility are covered, including room and board in semiprivate accommodations. Such services must be supported by a treatment plan approved in advance by the Benefits Manager. Custodial care and the provision of skilled nursing services incidental to custodial care are not covered. Coverage is limited to one hundred (100) days per Plan Year.

Care provided by a registered nurse or licensed practical nurse or a nursing agency for skilled nursing services is covered if the individual's condition: (1) requires skilled nursing services; and (2) visiting nursing care is not adequate. Coverage is limited to one hundred twenty (120) visits in a Plan Year.

Sterilization Procedures

Charges for elective sterilization procedures such as a tubal ligation or vasectomy are covered. Copayments, coinsurances, and deductibles, if any, will apply. Reversal of an elective sterilization is not covered.

Telehealth Services

Cigna Telehealth Connection, a free virtual care service, lets you connect with a board-certified doctors and licensed therapists via video chat or phone 24-hours a day, 7-days a week, including weekends and holidays.

Cigna's Telehealth Connection Services are different than providers offering a virtual office visit; virtual office visits/consultations offered outside of Cigna's Telehealth Connection will have applicable office visit copayments applied.

Cigna Telehealth Connection is for minor, non-life-threatening illnesses (e.g., cold or flu, rashes, sore throat, mild fever) and mental health needs (e.g., anxiety, depression, stress). Care for minor illnesses can also be provided to infants and children. For Telehealth Connection services contact MDLIVE. Medical Plan participants must first register before accessing services by either calling or completing an online registration. You can also download the MDLIVE for Cigna app to your smartphone/mobile device.

- For services, call MDLIVE at 888.632.2738 or log into www.myCigna.com, locate the "Talk to a doctor or nurse 24/7" callout, click "Connect Now" then "MDLIVE".

When not using Cigna Telehealth Connection, you may use Cigna Behavioral Health virtual covered services related to Mental Health and Substance Abuse. Go to myCigna.com to search for a telehealth specialist. Call to make an appointment with your selected provider; an applicable office visit copayment may apply.

Therapeutic Termination of Pregnancy

Services and supplies for therapeutic termination of pregnancy when the mother's life is in jeopardy, or there is a definitive diagnosis that the fetus has such a severe anomaly that it is considered nonviable and incompatible with life by at least two duly qualified physicians in the appropriate specialty (e.g., neonatology, pediatrics, OB/GYN, etc.) and with knowledge of the case, and the physicians provide their opinions in writing to the Benefits Manager.

Transplant Services (Human Organ and Tissue)

When approved in advance by the Benefits Manager, the Plan will cover services and supplies with respect to the following human organ transplants:

- Bone marrow, including treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants.
- Cornea
- Heart
- Kidney
- Liver
- Lung
- Pancreas
- Such other transplants as may be determined from time to time by the Plan.

To be eligible for coverage, the transplant must be medically necessary, and the Benefits Manager must approve, in advance, the procedure, treatment plan, attending physician and facility. Approved facilities will include only the following BJC Facilities: St. Louis Children's Hospital and Barnes-Jewish Hospital, or, if a service is not available from one of these BJC Facilities, another hospital which is approved, in advance, by the Benefits Manager. No benefits will be payable for any organ or tissue transplant that the Plan considers to be investigational, experimental, or for artificial or cross-species transplants.

Covered Transplant Services Include:

- Pre-transplant evaluation (inpatient or outpatient) services required to assess and evaluate a covered individual for acceptance into the transplant program and prepare the recipient for the transplant admission.
- Organ/tissue acquisition (inpatient or outpatient):
- For a living related kidney transplant, evaluation, and hospitalization for donor nephrectomy.

- For a bone marrow transplant, patient stem cell collection, bone marrow harvest of both donor and recipient, donor evaluation and cryo-preservation.
- For all other organ transplants, acquisition, physician services and transportation of organ and patient (if necessary).
- Covered services in connection with the donor shall be limited to the extent that other health care coverage of the donor does not cover such services. The Plan will pay secondary to the donor's coverage (see the section of this SPD entitled *Coordination of Benefits*)
- Inpatient care, surgical procedures, ancillary health care services and services of licensed health professionals, including but not limited to, physician services, nursing services and anesthesiology services.
- All inpatient and outpatient follow-up care that is transplant-related, including, but not limited to, post-transplant infection, organ rejection, cyclosporin toxicity, and additional inpatient or outpatient health care services required for completion of transplant protocol.
- Reasonable and necessary transportation, lodging and meal expenses, up to a lifetime maximum of $10,000, incurred by the covered individual who is receiving the transplant and an individual accompanying the recipient, when the covered individual who is receiving the transplant lives outside a fifty (50) mile radius of the transplant facility, to the extent authorized by the Benefits Manager.

Wellness/Preventive Care

Wellness and preventive care is generally covered at 100%--copayment and deductible do not apply if provided by a Network provider. If provided by an Out-of-Network provider, deductible and coinsurance will apply. Contact the Benefits Manager if you have questions about whether a specific service not listed below may be covered at 100%. Services covered at 100% include:

- Abdominal aortic aneurysm one-time screening for men ages 65-75 who have ever smoked
- Alcohol and Drug Use assessments for adolescents
- Alcohol Misuse screening and counseling
- Allergy injections without an office visit are covered at 100%, and as described above
- Behavioral and developmental/autism assessments/screenings covered to age 21
- Blood Pressure screening for children at 0 months to 17 years
- Blood Pressure screening for all adults (every 2 years at or after age 18)
- Breast Cancer Chemoprevention counseling for women at higher risk
- Breastfeeding equipment and supplies (requires a prescription and must be ordered through a BJC Pharmacy or Cigna EviCore). Please refer to the above section titled Breastfeeding Equipment and Supplies under Covered Medical Services.
- Breastfeeding support and nursing mothers counseling
- Cervical Dysplasia screening for sexually active females
- Cholesterol screening
- Colonoscopy--no age limits
- Contraceptive education and counseling
- COVID-19 screening and testing, whether from a Network or Out-of-Network provider (effective March 2, 2020). Effective January 15, 2022, the Plan will cover or reimburse up to eight (8) individual at-home over-the-counter COVID-19 Tests per participant per month (covered under the *Pharmacy Program*). A COVID-19 Test is a COVID-19 diagnostic test authorized by the U.S. Food and Drug Administration. This coverage does not apply to tests that are required for employment purposes.
- COVID-19 qualifying preventive treatment (may include an item, service, and/or immunization)
- Diabetic nutrition counseling (group and individual)
- Diabetic screening

- Diet counseling for adults at higher risk for chronic disease
- Depression screening
- Diagnostic X-rays or laboratory tests ordered in conjunction with wellness and preventive care visits are covered. If such services are received at a BJC or Network facility, the Plan will pay 100% after the office visit copayment. If the laboratory test is diagnostic (not associated with a preventive visit), it will be covered at 100% for the following services, if provided at a Network facility: colonoscopy, mammogram, PSA test, cholesterol, cervical cancer screening, colon cancer screening, blood sugar, blood pressure. If services are received at an Out-of-Network facility, the applicable deductible and coinsurance will apply.
- Domestic Violence counseling and screening
- Dyslipidemia screening for children at higher risk of lipid disorders
- Eye examination--one (1) per Plan Year by an optometrist or ophthalmologist.
- Family Planning Services specific to the:
  - Surgical sterilization procedures for women, and
  - Services for the insertion/removal of intrauterine devices, implants fitting diaphragm or cervical cap.
- Fluoride for dental cavity prevention and Fluoride Chemoprevention supplements for children without fluoride in their water source
- Genetic testing for breast cancer BRCA gene
- Gestational diabetes screening
- Gonorrhea preventive medication for the eyes of all newborns
- Hearing screening--one (1) per Plan Year
- Height, Weight and Body Mass Index measurements for children at 0 to 17 years
- Hematocrit or Hemoglobin screening for all children
- Hemoglobinopathies or sickle cell screening for newborns
- Human Papillomavirus (HPV) screening, (HPV) DNA Test high risk HPV DNA testing every five (5) years for women with normal cytology results who are aged 30 to 65
- Immunizations--pediatric and adult immunizations and inoculations for infectious disease
- Lead screenings to age 21
- Lung Cancer Screening – Low-dose CT in adults aged 55 to 80 years who have a 30 pack-year smoking history and currently smoke or have quit within the past 15 years
- Mammogram--no age limits
- Medical History for all children throughout development
- Newborn screenings 0-90 days: thyroid disease, phenylketonuria (PKU), sickle cell anemia
- Obesity screening
- Oral health counseling for children
- Osteoporosis screening for women 65 or older and age 60 or older if at increased risk for fractures
- Physical Exams--periodic pediatric and annual adult examinations
- Pregnancy screenings including anemia, iron deficiency, hepatitis B and Rh incompatibility
- Certain preventive prescription drugs (covered under the *Pharmacy Program*). This includes aspirin, folic acid, iron supplements, oral fluorides, certain contraceptives and emergency contraceptives, most generic and prescription nicotine replacement agents, vitamin D supplements and certain bowel preparation agents.
- Prostate examination--no age limits
- Sexually transmitted infection counseling, Human Immunodeficiency Virus (HIV) counseling and screening, and chlamydia, gonorrhea, and syphilis screening
- Tobacco Use screening for all adults and cessation interventions for tobacco users, expanded counseling for pregnant tobacco users

- Tuberculosis screenings to age 21
- Vision screening--one (1) per Plan Year
- Well-baby and well-child care
- Well-woman gynecological examination (consisting of a pelvic examination, pap test, manual breast examination and urinalysis) per Plan Year

Medical Exclusions

Coverage is not provided for any of the following medical services or supplies:

- Any service not expressly described as a covered medical service.
- Care for complications arising out of or from care that is not a covered medical service, except as described in *BJC's Clinical Trial Coverage Guidelines*.
- Care for conditions or complications of conditions for which no covered services are available.
- Services or supplies that are not medically necessary, as determined by the Benefits Manager.
- Services or supplies for which prior authorization by the Benefits Manager is not obtained as required in the section entitled *Services Requiring Prior Authorization.*
- Charges incurred prior to the covered individual's enrollment for coverage under the Plan.
- Charges by an Out-of-Network provider in excess of the reasonable and customary charge, except in connection with emergency and urgent care services.
- Care rendered by a provider who is a member of the covered individual's immediate family, even if such individual is a Network provider.
- Services or supplies that are not prescribed, performed, or directed by a physician or other licensed health professional licensed to perform, direct or prescribe such services or supplies.
- Care that the provider cannot legally provide or for which the provider cannot legally bill, or services or supplies, or any portion thereof available to a covered individual without charge or for which the covered individual is not legally obligated to pay.
- Care provided and billed by a licensed health care professional who is in training.
- Services or supplies received on or after the date of termination of coverage (unless coverage is continued under *COBRA* or *USERRA*), regardless of when the treated condition arose and whether or not the care is a continuation of care received prior to the termination.
- Costs related to any court appearance, proceeding, hearing or collection activities.
- Claims for services paid by a participant to a provider that are not submitted for reimbursement by the participant within twelve (12) months of the date the services were rendered.

Coverage is not provided for any of the following Mental Health and Substance Abuse Services, except as provided under *Covered Medical Services – Mental Health and Substance Abuse Services*:

- any court ordered treatment or therapy, or any treatment or therapy ordered as a condition of parole, probation or custody or visitation evaluations unless Medically Necessary and otherwise covered under the BJC medical Plan.
- treatment of disorders which have been diagnosed as organic mental disorders associated with permanent dysfunction of the brain.
- developmental disorders, including but not limited to, developmental reading disorders, developmental arithmetic disorders, developmental language disorders or developmental articulation disorders.
- counseling for activities of an educational nature.
- counseling for borderline intellectual functioning.
- counseling for occupational problems.

- counseling related to consciousness raising.
- vocational or religious counseling.
- I.Q. testing.
- custodial care, including but not limited to geriatric day care.
- psychological testing on children requested by or for a school system.
- occupational/recreational therapy programs even if combined with supportive therapy for age-related cognitive decline.

Coverage is also not provided for any of the following specific medical services or supplies:

- **Acupuncture**, acupressure, or hypnosis.
- Chronic **alcoholism, substance abuse or drug addiction treatment**, including nutritional based therapy, except as provided under *Covered Medical Services – Mental Health and Substance Abuse Services*.
- **Anesthesia services** when provided in connection with care that is not a covered service, except as described in the section entitled *Covered Medical Services*.
- **Behavior** modification, except as provided under *Covered Medical Services*.
- Charges for the procurement or storage of **blood, blood plasma or blood derivatives,** and blood donor expenses. (Only the administration and processing of blood is covered.)
- **Breast reconstruction** for disease, injury, or congenital anomaly in excess of one reconstruction per breast, except to restore symmetry as recommended by the oncologist or physician for the covered individual incident to a mastectomy as described under *Covered Medical Services*, or as determined to be medically necessary by the Benefits Manager.
- **Charges for failure to keep a scheduled visit**, late payment charges, and charges made for completion of forms and/or filing of claims.
- High-dose **chemotherapy** that requires bone marrow reconstitution, including stem cell reconstitution, for the treatment of malignant disease, except for the following:
  - When such treatment is part of a National Cancer Institute (NCI) phase III or IV trial, or the proposed treatment for the same condition is available elsewhere as part of an NCI phase III or IV trial.
  - When treatment is determined as medically necessary by the Benefits Manager.
  - In the case of breast cancer.

    A written request for prior authorization for an autologous bone marrow transplant to treat breast cancer must be submitted by the covered individual's physician and approved by the Benefits Manager prior to treatment. Only approved care at a facility designated by the Benefits Manager will be a covered service; care provided at any other facility will not be covered.
- **Collagen injections**, unless approved by the Benefits Manager.
- **Concierge medical fees** (e.g., fees paid to obtain future access to medical services)
- **Cosmetic or reconstructive procedures**, including, but not limited, to:
  - Pharmacological regimes.
  - Exercise programs or personal trainers.
  - Surgical excision or reformation of any sagging skin on any part of the body, unless determined medically necessary by the Benefits Manager.
  - Any services in connection with the enlargement, reduction, implantation or change in appearance of a portion of the body, including but not limited to the breasts, face, lips, jaw, chin, nose, ears, eyes, or genitals.
  - Procedures associated with the removal of scars, tattoos, and acne; skin abrasions or chemosurgery.
  - Hair transplantation and/or electrolysis depilation.

- Surgical treatment of scarring secondary to acne, chicken pox or other skin disorder; dermabrasion, chemical peel, salabrasion or collagen injections.
- Surgical treatment of scarring secondary to any surgery; radial keratotomy or other refractive correction procedure.
- Treatment of varicose veins by injections or any other treatment for superficial varicose veins, unless determined medically necessary by the Benefits Manager.
- Any other surgical or nonsurgical procedure that is primarily for cosmetic purposes.

This exclusion does not apply to medical procedures which are medically necessary and are not cosmetic, and to other types of plastic or reconstructive surgery when surgery is medically necessary to repair a functional disorder caused by disease, injury (where surgery is performed within six months of such injury) or congenital anomaly of a covered newborn child. Once function is restored, repeat treatments are excluded. This exclusion does not apply to breast reduction, when determined by the Benefits Manager to be medically necessary, or to prosthetic devices or reconstructive surgery necessary to restore symmetry incident to a mastectomy. Coverage for prosthetic devices and reconstructive surgery in connection with a mastectomy shall be subject to the same copayment as that applied to the mastectomy.

- **Custodial care, domiciliary care or rest cures**; care rendered and billed by a hotel, health resort, convalescent home, rest home, nursing home or other extended care facility, home for the aged, infirmary, school infirmary, institution providing education in special environments or any similar facility or institution, or other educational services, except when medically necessary and authorized in advance by the Benefits Manager. The Plan will have the sole discretion to determine whether care is custodial care, domiciliary care, a rest cure or otherwise excluded type of care. The fact that care has been recommended, provided, prescribed, or approved by a physician or other provider will not establish that the care is a covered service. Services or supplies that cannot reasonably be expected to lessen a covered individual's disability and to enable him or her to live outside an institution also are excluded.
- All **dental surgeries and services** (except as described under *Covered Medical Services*), including all related expenses and hospitalizations, related to the care, filling, removal or replacement of teeth or diseases of the teeth or gums, including, but not limited to:
  - Apicoectomy (dental root resection), orthodontics, root canal treatment, soft tissue impactions, alveolectomy and treatment of periodontal disease.
  - Special radiography for dental implant site selection care.
  - Maintenance and removal of dental implants and mandibular staple bone plates.
  - Treatment of temporomandibular disease except as described in *Covered Medical Services*. Treatment of temporomandibular joint syndrome is not covered.
  - Dental implants and the prosthetic superstructures fabricated thereon.
  - Treatment of bony impactions when covered under the dental benefits portion of the Plan.
  - Preprosthetic dental surgery, including, but not limited to, removal of tori and exostoses, vestibuloplasty, myotomy, bone grafts and ridge.
  - Orthognathic surgery (except when medically necessary as determined by the Benefits Manager), maxillary osteotomies, mandibular osteotomies.
  - Dental restoration due to tumors or cysts in the field of jaw resections.
  - The repair of direct injury to the teeth, replantation, transplantation, and stabilization of the teeth also are excluded, except as described in *Covered Medical Services*.
  - Frenectomy, except to correct ankyloglossia and transeptal fiberotomy.

This exclusion does not apply to physician services for any of the following:

- Surgical correction of cleft lip or cleft palate.
- Removal of stones from salivary ducts.
- Bony cysts of the jaws, torus palatine, leukoplakia, or malignant tissues.

- Freeing of muscle attachments.
- Other services and supplies when ordered or provided by a physician in order to protect the physical condition of the covered individual as a result of a particular non-dental physiological impairment, when authorized.

- Hospital and anesthesia care when rendered primarily for **dental services** (except as described under *Covered Medical Services*). This exclusion does not include facility and anesthesia care when a concurrent medical disease or illness exists that makes the facility and anesthesia care medically necessary and precludes treatment in the office setting. A concurrent disease or illness does not include phobias and behavioral or anxiety problems.
- **Dietary supplements or formula (**e.g., standardized or specialized infant formula for conditions other than inborn errors of metabolism or inherited metabolic diseases (including, but not limited to: food allergies; multiple protein intolerances; lactose intolerances; gluten-free formula for gluten-sensitive enteropathy/celiac disease; milk allergies; sensitivities to intact protein; protein or fat maldigestion; or intolerances to soy formulas or protein hydrolysates); food thickeners; dietary and food supplements; lactose-free products; products to aid in lactose digestion; gluten-free food products; weight-loss foods and formula; products to aid weight loss; normal grocery items; low carbohydrate diets; baby food; grocery items that can be blenderized and used with an enteral feeding system; nutritional supplement puddings; high protein powders and mixes; oral vitamins and minerals) except as otherwise described under *Covered Medical Services*.
- **Drugs and medicine**, including vitamins, not prescribed for use while the covered individual is an inpatient at a hospital, except as described in the *Pharmacy Program* section. This exclusion includes nutritional supplements, except those ordered by a physician in connection with home care requiring the covered individual to have a feeding tube, which is the primary source of nutritional support to the covered individual.
- **Durable medical equipment and prosthetic devices** except to the extent they qualify as covered services. Durable medical equipment which can be obtained over-the-counter will not be covered, regardless of the cost of such equipment.
- **Elective abortions** and related care, except as otherwise described under *Covered Medical Services*.
- Care received in the emergency room, or urgent care center, for a condition that does not meet the definition of an **emergency medical condition**. Mild fevers, nausea and headaches are some examples of conditions that are usually not emergencies.
- **Eyeglasses, contact lenses or the fitting of eyeglasses or contact lenses** (except for the initial pair of eyeglasses or contact lenses prescribed following cataract surgery, or bandage contact lenses when medically necessary), exercises or any medical care, services or supplies related to treatment of a refractive error (including, but not limited to radial keratotomy).
- Those health services, associated expenses or complications resulting from **experimental, investigational, or unproven services, treatments, devices, and pharmacological regimens.** The fact that an experimental, investigational, or unproven service, treatment, device, or pharmacological regimen is the only available treatment for a particular condition, will not result in coverage if the procedure is considered to be experimental, investigational, or unproven in the treatment of that particular condition. This exclusion does not apply to certain services rendered in connection with a clinical trial as described in the BJC HealthCare Medical Plan Provider Guide for Clinical Trials (see the *Clinical Trial Coverage Guidelines* section).
- Charges for supplies for use beyond the **first twenty-four (24) hours following discharge** from the hospital as an inpatient or following the provision of emergency care, including any prescription drugs intended primarily for home use.
- **Genetic testing** that is not Medically Necessary, including DNA paternity testing.
- To the extent permitted by law, medical care, services and supplies which are furnished by a hospital or facility operated by or at the direction of the United States **government** or any authorized agency thereof, or furnished at the expense of such government or agency or by a licensed health professional employed by such a hospital or facility, unless (i) the treatment is for an emergency medical condition, and (ii) the covered individual is not entitled to such treatment without charge by reason of status as a veteran, active or otherwise.

- **Group nutrition counseling** except for group diabetic nutrition counseling.
- **Group rehabilitative services** or rehabilitative services in a group setting**.**
- **Growth hormone therapy**. Medically necessary growth hormones are covered under the *Pharmacy Program* with prior authorization. Related treatment by a physician for growth deficiency must have prior authorization by the Benefits Manager.
- **Hair analysis**.
- **Hearing aids**, of any type, including but not limited to, bone-anchored hearing aids (BAHAs), air conduction and bone conduction devices. This exclusion does not apply to medically necessary cochlear implants.
- **Hospital confinement** for environmental change.
- Care for an injury or illness resulting from participation in, or in consequence of having participated in, an **illegal** occupation or the commission of an assault, felony, or other unlawful act.
- **Immunizations, vaccinations, examinations, or treatments** received for the sole purpose of obtaining or maintaining any license, or which relate to employment and/or insurance, or for travel, or an examination required prior to engaging in recreational activities, or by court order.
- Services provided in connection with **fertility treatment,** which exceed the medical Plan lifetime maximum as described in the *Fertility Services* section under *Covered Medical Services*. Prescription drugs used to stimulate ovulation or assisted reproductive technology (ART) are covered under the *Pharmacy Program* and apply to the Fertility Drug lifetime maximum as described in the *Pharmacy Program* section.
- **Injectable drugs** prescribed for self-administration and injectable drugs administered in any setting when being provided as a means of birth control, except as provided in *Pharmacy Program* section.
- A **job-related injury or illness**, or any illness or injury that results from work on your property for pay or profit.
- **Marital counseling**.
- Testing and treatment of **mental disabilities, defects, and deficiencies**; testing and diagnosis of learning disabilities and treatment of the behavioral aspects of learning disabilities or phobias; and testing and diagnosis of attention deficit disorder. This exclusion does not apply to mental health services as described earlier, except as provided under *Covered Medical Services* and *Covered Medical Services – Mental Health and Substance Abuse Services.*
- Services in connection with the treatment of a primary **mental illness** not classified in the International Classification of Diseases of the U.S. Department of Health and Human Services; or for mental illness, which is not normally susceptible to favorable modification, in accordance with generally accepted practice standards.
- Treatment of **military service-related diseases** for which the covered individual is legally entitled to receive treatment at government facilities.
- Services and supplies primarily or partially provided for **obesity therapy**, such as gastropexy, gastric bypasses, jejunal bypasses, gastric balloon procedures, stomach stapling and wiring of the jaw or any other surgical procedures and office visits associated with any weight reduction programs, unless such weight reduction programs are included in BJC's or the Benefits Manager's health education and information program, in which case reimbursement will be in accordance with the program guidelines, or as described in the *Bariatric Surgery* section.
- **Organ transplants** considered to be experimental or investigational as solely determined by the Plan. Organ transplants are a covered service only as described in the section called *Transplant Services (Human Organ and Tissue)*; any artificial, mechanical, or cross-species organ or tissue transplants are excluded from coverage.
- **Orthoptics** (a technique of eye exercises designed to correct the visual axes of eyes not properly coordinated for binocular vision).
- **Orthotics and care**, except when considered Medically Necessary.

- Charges made by a hospital for telephone, television, private hospital rooms (unless a private room is deemed medically necessary by the Benefits Manager) and other similar **personal comfort items**, which are not medically necessary.
- Provision of **personal convenience items** or services, including, but not limited to: barber services, guest meals, radio and television rentals, heating pads, hot water bottles, ice packs, devices and equipment used for environmental control or to enhance the environmental setting, including air conditioners, furnaces, humidifiers, dehumidifiers, electronic air filters and similar equipment and other like items and services and other like items and services.
- **Physical fitness** equipment, hot tubs, heated spas, pools, or memberships to health clubs.
- **Prenatal** and childbirth education (e.g., Lamaze class, Childbirth class, Early Pregnancy class, etc.).
- **Pregnancy of a dependent child**, except charges for medical complications when treatment is necessary to protect the life of the mother and certain wellness/preventive screenings recommended during pregnancy and required by law. (A cesarean section is not considered a complication.) Charges associated with the dependent child's newborn will not be covered.
- **Private-duty or special nursing care** except as provided under *Covered Medical Services* or as specifically approved by the Benefits Manager.
- Care for conditions that state or local law requires to be treated in a **public facility**.
- Services and associated expense for **removal of an organ** from a covered individual for purposes of transplantation into another person.
- **Reversal of sterilization** and related services.
- Care in a **self-care unit, apartment, or similar facility**, including those operated by or connected with a hospital.
- Care for **sexual dysfunction** unrelated to organic disease.
- Developmental **speech therapy**, cognitive rehabilitation, work therapy or other therapy services, except as provided under *Covered Medical Services* and *Covered Medical Services – Mental Health and Substance Abuse Services* for autism**.**
- **Telephone consultations**.
- Music **therapy**, biofeedback, voice therapy, remedial reading, recreational or activity therapy, all forms of special education, and supplies or equipment used for such purposes.
- Medical expenses for which a **third party** may be liable. Pending a determination of liability, the Plan may advance an amount equal to the benefits that would be payable if the third party is not liable. The Plan will have the right to recover these advances from any recovery from the third party in accordance with its reimbursement and subrogation rights as described in the section entitled *Right of Recovery* if it is determined through judgment, settlement or otherwise, that the third party is liable for such medical expenses.
- **Third-party mandated** physician exams, testing, reports, and treatment including but not limited to disability examinations, unless directly related to treatment of the covered individual.
- All services and supplies in connection with **tobacco cessation** (please refer to the section entitled *Tobacco Cessation & Tobacco Use Surcharge*, or the section entitled *Pharmacy Program* for coverage information).
- **Transportation expenses**, other than ambulance, whether or not recommended or prescribed by a physician or other licensed health care professional, unless deemed medically necessary by the Benefits Manager, except as otherwise described under *Covered Medical Services*.
- Care for any condition suffered as a result of any act of **war**, whether declared or undeclared, insurrection or any atomic explosion or other release of nuclear energy (except when being used solely for the medical treatment of a condition), or while on active or reserve military duty.
- **Wigs** (unless for hair loss as a result of chemotherapy treatment for a diagnosis of cancer as described under *Covered Medical Services)*, hairpieces and hair implants for any reason.
- Care for any condition, disease or injury for which care, treatment or compensation is available to the covered individual, in whole or in part, under a **workers' compensation or other employer liability**

law, whether or not a covered individual claims and receives covered services thereunder in a lump sum or otherwise.

Claims Filing, Second Opinions and Utilization Review Procedures

Claims for Benefits

You do not have to file a claim for benefits if you use a BJC Facility or other Network provider--your provider will submit the claim directly to the applicable Benefits Manager, as applicable. However, if you receive services from an Out-of-Network provider, you will be responsible for submitting claims to the applicable Benefits Manager. Your provider may do this on your behalf, but you may need to submit a fax or paper claim to the applicable Benefits Manager. All claims must be submitted for reimbursement within twelve (12) months from the date the services were rendered in order to be eligible for coverage.

Second Opinions

You may obtain a second opinion from another physician if you have received an initial diagnosis which requires major surgery or other treatment that requires general anesthesia or if you are diagnosed with a serious illness involving loss of a bodily part or function or other debilitating disease. This opinion will be at no additional cost to you beyond the applicable copayment that you would otherwise pay for an initial medical opinion or consultation from such provider. If there are no Network providers with the expertise necessary to provide a second medical opinion, the Benefits Manager will arrange for a referral to a physician with the necessary expertise. In that case, you will incur no additional cost beyond the applicable copayment and/or coinsurance that you would have otherwise paid if the services were rendered by a Network physician. If, however, you choose an Out-of-Network provider when a Network provider is available, you will be responsible for the applicable deductible and out-of-network copayment and/or coinsurance.

Utilization Review Procedures

The utilization review program is designed to ensure that you get the most appropriate, cost-effective care for your condition(s). Under the utilization review program, the Benefits Manager determines whether certain services and supplies are medically necessary or otherwise meet the requirements for coverage by the Plan. Services that are authorized by the Benefits Manager will be covered subject to all the other terms and conditions of the Plan. Services that are not authorized by the Benefits Manager will not be covered and you will be financially responsible if you choose to receive those services. Generally, the provider will request prior authorization on your behalf, particularly if you use a BJC Facility or Network provider. However, if you use an Out-of-Network provider, it is your responsibility to make sure that the prior authorization is obtained. **If you use an Out-of-Network provider and do not obtain prior authorization (precertification), the services will not be covered, and you will be responsible for paying the charges**. Note that this does not apply if you use a BJC Facility or Network provider. In those cases, it is the responsibility of that provider to obtain the appropriate prior authorization, and you will not be held responsible for the charges if the provider fails to obtain such authorization.

Glossary of Medical Plan Terms

Adverse Determination

A determination by the Benefits Manager or its designated utilization review organization that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, is not covered under the Plan. This could be because the service is specifically excluded under the Plan or does not meet the Plan's requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the payment for requested service is therefore denied, reduced, or terminated.

Allowable Charge (Allowed Amount)

The maximum amount on which payment is made under the Plan for a *Covered Medical Service*. This Allowable Charge may be paid as a combination of your copayment, your deductible, your coinsurance, and/or what the Plan pays. The Allowable Charge is typically a discounted charge rather than the actual charge. It may be helpful to consider an

example: You have just visited your primary care physician (PCP) for an earache. The total charge for the visit comes to $100. If the PCP is a member of Cigna's OAP Network, he or she may be required to accept $80 as payment in full for the visit - this is the Allowable Charge. The Plan will pay all or a portion of the $80, minus the PCP copayment you may owe. The remaining $20 is the provider discount. You cannot be billed for this provider discount. If, however, the PCP you visit is not a Network provider, then you may be held responsible for everything that the Plan will not pay, up to the full charge of $100.

Benefits Manager

The entity or entities to whom the Plan Administrator has delegated certain duties and powers under the Plan, including but not limited to: interpretation of plan provisions, payment of claims, decision of first-level appeals, and other administrative functions. For the BJC Choice Plus and BJC Choice medical coverage options, the Benefits Manager is Cigna.

BJC Facility (Choice Plus and Choice Medical Plan options only)

Any of the following facilities:

- Alton Memorial Hospital
- Alton Memorial Rehab & Therapy (skilled nursing and rehab services only)
- Athletico Physical Therapy (various locations throughout St. Louis, MO-IL; Farmington and Sullivan)
- BJC Corporate Health Services (for covered services only)
- BJC Home Care Services
- Barnes-Jewish Extended Care (skilled nursing and rehab services only)
- Barnes-Jewish Hospital
- Barnes-Jewish and Washington University Orthopedic Center
- Barnes-Jewish St. Peters Hospital
- Barnes-Jewish West County Hospital
- Christian Extended Care & Rehabilitation (skilled nursing and rehab services only)
- Christian Hospital
- Heart Care Institute and Heart Care Institute Affiliated Services (technical fees only)
- Memorial Care Center (Memorial HealthCare Center) (skilled nursing and rehab services only)
- Memorial Hospitals
- Missouri Baptist Medical Center
- Missouri Baptist Sullivan Hospital
- Northwest HealthCare
- Parkland Health Center - Bonne Terre
- Parkland Health Center - Farmington
- Progress West Hospital
- Siteman Cancer Center (only for services billed by any of the named BJC Facilities)
- St. Louis Children's Hospital (includes St. Louis Children's Specialty Care Center)
- Participating BJC Collaborative Partners
- Rehabilitation Institute of St. Louis* (Effective April 1, 2022)

NOTE: Salem Township Hospital, Barnes-Jewish Dialysis Center, Farmington Dialysis Center, and Rehabilitation Institute* (1/1/2022 – 3/31/2022) are not BJC Facilities.

*Effective April 1, 2022, the Rehabilitation Institute of St. Louis will be considered a BJC Facility.

Effective April 1, 2021, Boone Hospital Center, Boone Hospital Home Care and Hospice, and Boyce and Bynum Pathology Labs P.C. and Boyce and Bynum Pathology Laboratories are not BJC Facilities.

This list may be modified from time to time. For an updated listing of the BJC Facilities, please go to mycigna.com.

Cardiac Rehabilitation

Medically supervised interventions that include exercise training, counseling and behavioral management aimed at limiting physical and other damage from heart disease.

Coinsurance

After the deductible is met, coinsurance is a percentage of the Allowable Charge that the covered individual must pay directly to a provider or facility for *Covered Medical Services*.

Condition

Any illness, disease, bodily injury, bodily defect, or abnormality representing an interruption, cessation, or disorder of body functions, systems, or organs. Condition includes signs and/or symptoms that may indicate an underlying illness, disease, bodily injury, bodily defect, or abnormality. Condition also includes pregnancy, mental health, alcoholism, drug addiction or substance abuse.

Copayment

The flat dollar amount that the covered individual must pay directly to a provider or facility, usually at the time of service, for *Covered Medical Services.*

Custodial Care

Non-medical services that do not seek to cure but are provided primarily for the convenience of the patient or his or her family, the maintenance of the patient, or to assist the patient in meeting his or her activities of daily living, rather than primarily for therapeutic value in the treatment of a condition. Custodial care includes, but is not limited to, help in walking, bathing, dressing, eating, preparation of special diets, supervision over self-administration of medications not requiring constant attention of trained medical personnel, or acting as a companion or sitter, or any similar care that is determined by the Benefits Manager to be custodial.

Deductible

The amount that the covered individual must pay directly to a provider or facility for Covered Medical Services before the Plan starts paying (as described in the section *Deductibles, Copayments, Coinsurance and Maximums*).

Durable Medical Equipment (DME)

Equipment which is:

- Made to withstand prolonged use.
- Made for and mainly used in the treatment of a disease or injury.
- Suited for use in the home.
- Not normally of use to persons who do not have a disease or injury.
- Not available over-the-counter.

Emergency Medical Condition

The sudden and, at the time, unexpected onset of a health condition that requires immediate hospital treatment to avoid physical impairment, medical complications, or loss of life. The Plan Administrator has the sole discretion to determine afterward if a medical emergency existed at the time medical services were received by a covered individual.

Emergency Services

Covered inpatient and outpatient services that are:

- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

Experimental or Investigational Services

Services including, but not limited to, transplants, which are experimental or investigational or educational in nature, or any treatment (including pharmacological regimes) not recognized as generally accepted medical practice by the medical profession. Criteria for determining whether or not a procedure or treatment will be considered experimental or investigational will include, but not be limited to, the following:

- Whether the service has final approval from the appropriate government regulatory bodies (FDA or other regulatory authority as appropriate).
- Whether the procedure or treatment is generally accepted by the medical profession (opinions may be requested from TEC, CMSS, NIH, AMA, OTA, and CEAP or other organizations as determined by the Benefits Manager).
- Whether the scientific evidence permits conclusions concerning the effect of the service on health outcomes, and whether, in the predominant opinion of the experts, as expressed in the published authoritative literature, that (i) usage should be substantially confined to research settings, or (ii) that further research is necessary, or the written protocol describes among its main objectives the necessity, to determine safety, toxicity, efficacy, or effectiveness of that service compared with conventional treatment alternatives.
- Whether the service is being delivered or should be delivered subject to the approval and supervision of an institutional review board as required and defined by federal regulations, particularly those of the Food and Drug Administration or the Department of Health and Human Services.
- The failure rate and side effects of the treatment or procedure.
- Whether other, more conventional methods of treatment have been exhausted.
- Whether the service is as beneficial as any established alternatives.
- Whether the procedure or treatment is medically necessary and is expected to improve the net health outcome of the covered individual.
- Whether the procedure or treatment is recognized for reimbursement by Medicare, Medicaid, other insurers or self-insured plans, or other applicable third-party payers.
- Whether the procedure or treatment results from a complication of an experimental or investigational service.

Procedures in question for their experimental or investigational nature will be reviewed by appropriate members of the medical profession for recommendation. To be considered a covered service, the service in question must not be determined to be experimental or investigational and the covered individual must meet the criteria for treatment or other procedure with regard to age, general health, etc., and have been determined to be a good candidate for the procedure or treatment by an accredited facility. Final decisions regarding coverage under the Plan will be at the sole discretion of the Plan Administrator.

Notwithstanding the above, in no event will the treatment of breast cancer by dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants, when performed pursuant to nationally accepted peer review protocols utilized by breast cancer treatment centers experienced in dose-intensive chemotherapy/autologous bone marrow transplants or stem cell transplants, be considered experimental or investigational.

This exclusion does not apply to care that would be otherwise medically necessary in the absence of a clinical trial or experimental/investigational service. Please refer to the *Covered Medical Services* – Clinical Trials section.

This exclusion does not apply to covered therapy services related to autism as described in C*overed Medical Services* under *Autism Spectrum Disorders Treatment* or in *Covered Medical Services – Mental Health and Substance Abuse Services*.

Home Health Care Agency

An agency or organization which is duly licensed, when required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.

Hospice Care or Services

A program of care that is provided by a hospital, skilled nursing facility, hospice, or a duly licensed hospice care agency which meets the following requirements:

- It is approved by the applicable Benefits Manager.
- It focuses on a palliative rather than curative treatment for covered individuals who have a medical condition and a prognosis of less than six (6) months to live.

Hospice Facility

A facility, or distinct part of a facility, which:

- Mainly provides inpatient hospice care to terminally ill persons.
- Charges its patients.
- Meets any licensing or certification standards for the jurisdiction in which it is located.
- Keeps a medical record on each patient.
- Provides an ongoing quality assurance program that includes reviews by physicians other than those who own or direct the facility.
- Is run by a staff of physicians; one of whom must be on call at all times.
- Provides nursing services under the direction of a registered nurse twenty-four (24) hours a day.
- Has a full-time administrator.

Hospital

An acute care, duly licensed institution which is primarily engaged in providing medical care and treatment for sick and injured persons on an inpatient basis through medical, diagnostic, and major surgical facilities. All services must be provided on its premises under the supervision of a staff of physicians and with 24-hour-a-day nursing and physician service.

Medically Necessary

Care rendered for the diagnosis or treatment of a condition that is, in the judgment of the applicable Benefits Manager (depending on the service), generally accepted as being necessary and appropriate according to the prevalent standards of medical care practice as determined by the applicable Benefits Manager. The level and amount of care must not be greater than is necessary and appropriate according to said standards. For example, care provided on an inpatient basis is not medically necessary if the care could appropriately have been provided on an outpatient basis according to said standards. Medically necessary care will also include those preventive screenings and services specifically described in this SPD.

The Plan Administrator has the sole discretion to determine whether the care is medically necessary. Care will not be considered medically necessary simply because it is rendered or prescribed by the covered individual's physician or other licensed health care professional. The applicable Benefits Manager or the Plan Administrator may consult with professional peer review committees or other appropriate sources for recommendations. If proper prior authorization is made for services deemed medically necessary, the Plan will not seek reimbursement (outside of applicable Plan provisions) for the cost of this care if it is later determined to be NOT medically necessary. This applies only if the covered individual was not notified before receiving the care that it would not be medically necessary.

Mental Disorder

A disease commonly understood to be a mental disorder whether or not it has a physiological or organic basis and for which treatment is generally provided by or under the direction of a licensed mental health professional such as a psychiatrist, a psychologist, or a psychiatric social worker. A mental disorder includes but is not limited to: schizophrenia; bipolar disorder; panic disorder; major depressive disorder; psychotic depression; obsessive-compulsive disorder and any other conditions classified as mental disorders in the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders, but shall not include mental retardation.

Mental Health Provider

A provider, including appropriately licensed facilities, whose training and/or licensure, as applicable, permits such provider to provide treatment of mental health disorder, including Licensed Clinical Professional Counselors.

Mental Health Residential Treatment Center

An institution which specializes in the treatment of psychological and social disturbances that are the result of Mental Health conditions; provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; provides 24-hour care, in which a person lives in an open setting; and is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Mental Health Services

Services that are required to treat a disorder that impairs the behavior, emotional reaction or thought processes. In determining benefits payable, charges made for the treatment of any physiological conditions related to Mental Health will not be considered to be charges made for treatment of Mental Health.

Network Provider

A hospital, physician or other licensed health professional or other entity that contracts with Cigna's LocalPlus network, Cigna's Open Access Plus network or Cigna's Behavioral Health network to provide covered services to covered individuals.

Out-of-Network Provider

A hospital, physician or other licensed health professional or other entity that is not a BJC Facility or does not contract with Cigna's LocalPlus network, Cigna's Open Access Plus network or Cigna's Behavioral Health network.

Obsolete Care

Care that is no longer generally accepted as standard care according to the prevalent standards of medical care practice. At its sole discretion, the Benefits Manager and/or the Plan Administrator may consult with professional peer review committees or other appropriate sources for recommendations

Out-of-Pocket Maximum (Annual)

The most that any individual (or family) must pay under the Plan in any one Plan Year, as described in the section entitled *Deductibles, Copayments, Coinsurance and Maximums* in this SPD.

Physician

A legally qualified and licensed physician or surgeon.

Plan Year

A 12-month calendar year, beginning on January 1st and ending on December 31st of the same calendar year.

Prior Authorization

The Plan or applicable Benefits Manager has given approval for payment for certain services to be performed. Prior Authorization or Pre-Authorization does not guarantee payment if you are not eligible for Covered Services at the time the service is performed. Please refer to the *Services Requiring Prior Authorization* section in this SPD.

Pulmonary Rehabilitation

A comprehensive program for the management of patients with substantial chronic lung disease. Includes diagnostic testing, monitored dynamic exercise and education under the direct supervision of a qualified physician.

Reasonable and Customary Charge

The charge for a covered service which is the lower of:

- The provider's usual charge for furnishing such service.

- The charge that is determined by the Plan Administrator to be the prevailing charge level made for the service or supply in the geographic area where it is furnished (usually, the Medicare reimbursement for such service).

In determining the reasonable charge for a service or supply that is unusual, not often provided in the area, or provided by only a small number of providers in the area, the Plan Administrator may take into account factors such as: the complexity, degree of skill needed, type or specialty of the provider, range of services provided by a facility and the prevailing charge in other areas.

Short-Term Rehabilitation Facility

An institution that meets the following requirements:

- Mainly provides a program for diagnosis and short-term inpatient rehabilitation of injured and sick persons.
- Charges for services.
- Has a staff of physicians with admitting privileges.
- Prepares and maintains a written plan of treatment for each patient and has a staff of physicians responsible for each patient.
- Has a staff of physicians specializing in physical medicine and rehabilitation directly involved in the treatment program, one of whom is present at all times during the treatment day.
- Provides on the premises, twenty-four (24) hours a day:
    - Infirmary-level medical services (and provides or arranges with a hospital in the area for any other medical services that may be required).
    - Skilled nursing care by licensed nurses who are directed by a full-time registered nurse.

Skilled Nursing Facility

A facility which is licensed by the appropriate regulatory authority to provide inpatient covered members with skilled nursing care and related services or short-term rehabilitative therapy.

Skilled Nursing Services

A visit of not more than four (4) hours per day by a registered nurse or licensed practical nurse for the purpose of doing specific skilled nursing tasks, or private duty nursing by a registered nurse or licensed practical nurse. Skilled nursing services do not include:

- Services that do not require the education, training and technical skills of a registered nurse or licensed practical nurse, such as transportation, meal preparation, charting of vital signs and companionship activities.
- Private duty nursing care given while the covered individual is an inpatient in a hospital or other health care facility.
- Care provided to help a covered individual in the activities of daily living, such as bathing, feeding, personal grooming, dressing, getting in and out of a bed or a chair or toileting.
- Care provided solely for skilled observation except for:
- Observation for no more than one four-hour period per day for a period of no more than ten (10) consecutive days following the occurrence of a change in patient medication; Observation by a physician in conjunction with emergency services or urgent care services or at the onset of symptoms indicating the likely need for such services;
- Observation after surgery; or
- Observation upon a release from inpatient confinement.
- Services provided solely to administer oral medicines, except where the law requires that a registered nurse or licensed practical nurse administer such medicines.

Substance Abuse

The psychological or physical dependence on alcohol or other mind-altering drugs that requires diagnosis, care, and treatment. In determining benefits payable, charges made for the treatment of any physiological conditions related to rehabilitation services for alcohol or drug abuse or addiction will not be considered to be charges made for treatment of Substance Abuse.

Substance Abuse Residential Treatment Center

An institution that: (i) specializes in the treatment of Substance Abuse, focusing on stabilization and improvement of functioning and reintegration with family or significant others; (ii) provides a subacute, structured, psychotherapeutic treatment program, under the supervision of Physicians; (iii) provides 24-hour care, in which a person lives in an open setting; and (iv) is licensed in accordance with the laws of the appropriate legally authorized agency as a residential treatment center.

Urgent Care

Services which can be provided in a medical office, hospital emergency room or urgent care center for the treatment of non-life-threatening conditions which require immediate medical attention to minimize severity and prevent complications.

Urgent Care Center

A licensed facility, not including a hospital, which provides urgent care limited to the immediate treatment of an injury or disease.

Utilization Review

A set of formal techniques designed to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of, health care services, procedures, or settings. Techniques may include ambulatory review, prospective review, second opinion, certification, concurrent review, case management and discharge planning.

PHARMACY PROGRAM

If you enroll for coverage under the BJC Signature, BJC Choice Plus or BJC Choice medical coverage option of the Plan, your pharmacy benefits are administered by Express Scripts, Inc. Only participants enrolled in a BJC medical option (Signature, Choice Plus, or Choice) of the Plan are eligible for pharmacy benefits. Your pharmacy benefits (covered drugs, plan provisions and copayments) are the same under each of the medical options.

How the Plan Works

Your medical ID card should be used as your pharmacy ID card. To receive benefits under the Plan, simply present your ID card at a participating pharmacy. You should inform the pharmacy of your BJC prescription drug coverage when you order a prescription. This allows the pharmacy to handle the administrative process before it is mailed, or you arrive at the pharmacy to pick up the prescription.

The Express Scripts participating retail pharmacy network under the Plan will only include Walgreens or Walgreens' Affiliate Pharmacies (not other retail pharmacies). Participants may obtain covered drugs at any Walgreens or Walgreens' Affiliate pharmacy, subject to the provisions below in this *Pharmacy Program* section.

ALL REFILLS in Missouri and Illinois need to be filled through the Family Care Central Pharmacy (Mail-Order); refills not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of the drug. Exceptions may apply. You still have the option of filling non-specialty new prescriptions (first fills) through the Family Care Central Pharmacy, any BJC Pharmacy, or any Select Out-of-Area Pharmacy (SOOA) at the lowest copayment for that specific medication. A new prescription (first fill) can also be filled at an Express Scripts Participating Walgreens Pharmacy at a higher copayment.

There are four (4) copayment tiers for covered prescription drugs in the Plan. These are listed from (generally) lowest copayment to highest:

- Generic
- Preferred Brand-Name
- Non-Preferred Brand-Name
- Specialty

Copayments will also vary based on the type of drug you select and your situation. For example, your prescription may fall into one of the following categories:

- Emergency Fill
- Maintenance Drug
- Prior Authorization

Choosing a Brand drug when a Generic is Available

A description of the types of drugs covered under the Plan is listed in this SPD, and it is updated from time to time. To find out if a specific drug is covered under the Plan, contact Express Scripts at 1-866-273-5779, or go to express-scripts.com and log in as a member to view the various lists of covered drugs and on which tier they will be paid (generic, preferred brand-name, non-preferred brand-name, and specialty). You may also find these drug lists on BJCtotalrewards.org.

There is an annual out-of-pocket maximum that limits the amount each member needs to pay for services at a BJC, Select Out-of-Area, and Express Scripts Participating Walgreens Pharmacy. See the section called *Schedule of Benefits - Pharmacy*.

Generally, you will receive greater benefits when you use the Family Care Central Pharmacy. Similar benefits are also available from Select Out-of-Area Pharmacies as noted in the section called *Pharmacy Locations*. For a **higher** copayment, benefits also will be provided at Express Scripts Participating Walgreens Pharmacies.

Helpful Hints for Using Your Pharmacy Benefits

The more you know about your covered prescription medications, the better they will work. Drug information sheets are given with all new prescriptions—read the sheets and consult your physician or pharmacist if you have any questions. Or, you may log on to express-scripts.com, which has links to drug and health information sites.

It is especially important to talk to your health care providers about over-the-counter drugs and herbs and how they might interact with your prescription medication.

FDA-approved equivalent generic drugs purchased from a BJC or Select Out-of-Area Pharmacy provide the best value to you and the Plan.

Schedule of Benefits - Pharmacy

In general, the Plan pays all of the cost for covered prescription drugs filled at designated pharmacies after you make the appropriate copayment. Notwithstanding the foregoing, refills not processed through the Family Care Central Pharmacy will result in significantly higher cost to you. Exceptions may apply. The copayments vary based on the type of drug (as described in the table below), the prescribed length of the prescription and the type of pharmacy you choose.

	30-day Supply* 1st Fills ONLY (MO & IL)		**30-day / 90-day Supply** 1st Fills & Refills (MO & IL)**
	BJC or Select Out-of-Area Pharmacy	**Express Scripts Participating Walgreens Pharmacy**	**Family Care Central Pharmacy (Mail Order)**
Generic Drug	$10	$25	$10 / $25
Preferred Brand-Name Drugs	$30	$75	$30 / $75
Non-Preferred Brand-Name Drugs	$75	$150	$75 / $150
Specialty Drugs* **	$50		
Annual Out-of-Pocket Maximum **Per Individual** **Per Family**	 $2,000 $4,000		

* All refills in Missouri and Illinois must be filled through the Family Care Central Pharmacy, unless the drug is on the exemption list.
Copays noted above for 30-day Supply apply to 1st fills.
Refills not processed through the Family Care Central Pharmacy will result in significantly higher cost to you. (Exceptions may apply.)

** For approved 90-day maintenance medications only. Available only through the Family Care Central Pharmacy.

*** All Specialty Drug prescriptions need to be directed to the Family Care Central Pharmacy. This includes 1st fills and refills. Copay is $50 if filled through the Family Care Central Pharmacy or through an Express Scripts Participating Walgreens Pharmacy. Refill requirements for Specialty Drugs may vary. Exceptions and special requirements are posted on BJCtotalrewards.org.

Annual Out-of-Pocket Maximum

The Plan provides protection from catastrophic prescription drug expenses by capping your share of eligible out-of-pocket expenses at $2,000 per individual member (or $4,000 per family) per Plan Year for drugs obtained at BJC, Select Out-of-Area, and Express Scripts Participating Walgreens Pharmacies (see *Pharmacies You Can Use*). This feature is called the prescription drug "annual out-of-pocket maximum." After out-of-pocket copayments reach the applicable annual out-of-pocket maximum, BJC will pay 100% of all remaining drug expenses at BJC, Select Out-of-Area, and Express Scripts Participating Walgreens Pharmacies for the remainder of the year.

The copayment for each prescription counts toward each person's annual out-of-pocket maximum only when the prescription is filled at the Family Care Central Pharmacy, a BJC Pharmacy, Select Out-of-Area Pharmacy, or Express Scripts Participating Walgreens Pharmacy

Unless a Plan exception applies, the additional amount you must pay for purchasing a Preferred Brand-Name or Non-Preferred Brand-Name drug when a Generic drug is available does not count toward the annual out-of-pocket maximum, and you will have to pay the additional amount even after the maximum is reached. This amount will not be eligible for reimbursement under the Plan. In addition, any amounts offset by a secondary payor or third-party (e.g., manufacturer coupons, rebates, coordination of benefits, MO Medicaid) do not count towards your annual out-of-pocket maximum. When receiving such secondary payor or third-party assistance and utilizing an Express Scripts Participating Walgreens Pharmacy, the member must provide this documentation to Express Scripts.

Expenses that Count Toward the Annual Out-of-Pocket Maximum

Copayments and the entire discounted cost of refills (as described above) for prescriptions from the Family Care Central Pharmacy, a BJC Pharmacy, Select Out-of-Area Pharmacy, and Express Scripts Participating Walgreens Pharmacy count toward the out-of-pocket maximum.

Expenses that Do Not Count Toward the Annual Out-of-Pocket Maximum

- The higher cost that you pay for choosing a Preferred Brand-Name drug or Non-Preferred Brand-Name drug when a generic is available unless a Plan exception applies.
- The cost that you pay for choosing NOT to refill a prescription as required at the Family Care Central Pharmacy unless a Plan exception applies.
- Certain specialty pharmacy drugs that are considered non-essential health benefits.
- Your cost for any prescriptions purchased from a pharmacy that does not participate in the Plan.
- Your cost for any drugs that are not covered by the Plan.
- Any amounts offset by a secondary payor or third-party as described above.

Description of Covered Drugs

Generally, the Plan covers most drugs prescribed by a physician. Several lists are provided for your use to help in understanding what drugs are covered. These lists are updated periodically and may be found on BJCtotalrewards.org or express-scripts.com.

Drugs that bear the statement "Caution: Federal law prohibits dispensing without a prescription," when prescribed by a licensed practitioner not related to the patient and not specifically excluded in the section called *Pharmacy Exclusions*. These drugs will include the following types:

- Insulin, insulin syringes, test strips, Novopen devices (when prescribed by a doctor) and insulin pump tubing and supplies.
- Other self-administered drugs, as recognized by the FDA as appropriate for self-administration regardless of the patient's ability to self-administer subject to prior authorization requirements where applicable.
- Certain smoking-cessation products. A physician's prescription is required.
- Many other generic and brand legend drugs approved by the FDA and specifically covered by the Plan.

This is not all-inclusive. Please contact Express Scripts at 1-866-273-5779 or visit on-line at express-scripts.com for more information on descriptions of covered drugs.

Fertility Drugs

Coverage is limited to a lifetime maximum of $2,500 per member under the *Pharmacy Program* (additional $7,500 lifetime maximum coverage for medical claims under the medical Plan).

Services include, but are not limited to, covered fertility drugs which are administered or provided by a Physician.

Infertility is defined as the inability of opposite sex partners to achieve conception after one (1) year of unprotected intercourse or the inability of a woman to achieve conception after six trials of artificial insemination over a one-year period. This benefit includes diagnosis and treatment of both male and female infertility.

Types of Drugs

Prescription drugs are classified into one of four (4) copayment tiers under the BJC Plan: Generic, Preferred Brand-Name, Non-Preferred Brand-Name and Specialty drugs.

The Plan provides a drug list to assist you and your doctor with selecting covered prescription drugs. The BJC drug list is designed to direct your physician to medications that provide the best combination of effectiveness and cost relative to available alternatives. You are responsible for sharing this list with your doctor. The list of drugs is updated periodically and is made available to employees on BJCtotalrewards.org, or you may contact Express Scripts by logging in as a BJC member at express-scripts.com.

The drug list is organized by class. A "drug class" refers to a category or family of drugs used to treat a certain type of disease, symptom, or condition. Not all classes of drugs are included on the drug list, and the Plan reserves the right to add or delete classes of drugs, or to otherwise revise this list, at any time.

Generic Drugs

Generic Drugs are low-cost alternatives that offer the same level of quality and safety as their brand-name equivalents. You receive the highest level of benefit (your lowest out-of-pocket cost) from the Plan when you purchase generic drugs. Using Generic Drugs maximizes the value to both you and BJC by providing the same therapeutic effect as the more expensive equivalent name brand but at a fraction of the cost.

Preferred Brand-Name Drugs and Non-Preferred Brand-Name Drugs

When a generic equivalent for your prescription does not exist, you and your doctor will need to choose whether your prescription will be filled with one of the Plan's Preferred Brand-Name Drugs or a Non-Preferred Brand-Name Drug. Preferred Brand-Name Drugs have a lower copayment than Non-Preferred Brand-Name drugs. Generally, the cost is lower if you choose the Preferred Brand-Name Drugs when Generic Drugs are unavailable.

If there are no Preferred Brand-Name Drugs for a covered class, you will pay the higher copayment for a Non-Preferred Brand-Name Drug.

Generic Drug Requirement

You can help keep your copayments and premium contributions as low as possible without sacrificing quality by utilizing Generic Drugs whenever they are available. Regardless of the reason, if you or your doctor elects a Preferred Brand-Name Drug or a Non-Preferred Brand-Name Drug when a generic equivalent is available and medically appropriate, you can receive the equivalent Preferred Brand-Name Drug or Non-Preferred Brand-Name Drug (except when Plan exclusion), but you will pay the difference in the cost of the two drugs, plus the regular Generic Drug copayment. This difference in cost will not be applied toward the annual out-of-pocket maximum unless an exception is made, in writing, through the exception process. Please contact Express Scripts at 1-866-273-5779 to request an exception.

Specialty Drugs

Specialty Drugs cost the most and can require special handling, administration, or monitoring. They are used to treat complex, chronic, and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C and hemophilia. **All Specialty Drug prescriptions must be directed to the Family Care Central Pharmacy.**

Pharmacies You Can Use

ALL REFILLS in Missouri and Illinois need to be filled through the Family Care Central Pharmacy; refills not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of the drug. Exceptions may apply. You still have the option of filling non-specialty new prescriptions (first fills) through the Family Care Central Pharmacy, any BJC Pharmacy, or any Select Out-of-Area Pharmacy (SOOA) at the lowest copayment for that specific medication. A new prescription (first fill) can also be filled at an Express Scripts Participating Walgreens Pharmacy at a higher copayment.

There are four (4) categories of pharmacies available for use under the Plan, as shown below. Please also refer to the list of *Pharmacy Locations* in this SPD.

Family Care Central Pharmacy (formerly BJC Employee Mail-Order Pharmacy) is a mail-order pharmacy that can deliver 30-day first fills (new prescriptions), refills, 90-day supplies of maintenance medications and all specialty drugs. In order to receive the highest benefits and keep your out-of-pocket costs the lowest, ALL REFILLS in Missouri and Illinois need to be filled through the Family Care Central Pharmacy.

BJC Pharmacies include five (5) outpatient pharmacies that are located within BJC Facilities, the Family Care Central Pharmacy (that provides mail-service only), and pharmacies designated only for discharge prescriptions or infusion services.

Select Out-of-Area Pharmacies are designated specifically for BJC employees who do not have easy access to BJC Pharmacies.

Express Scripts Participating Walgreens Pharmacy is any Walgreens pharmacy, or Walgreens Affiliate pharmacy, within the Express Scripts National Network. Information for specific Walgreens, or Walgreens' Affiliate, pharmacies can be obtained by contacting Express Scripts at 1-866-273-5779 or express-scripts.com.

Family Care Central Pharmacy Requirement

ALL REFILLS in Missouri and Illinois will need to be filled through the Family Care Central Pharmacy in order to obtain the lowest possible copayment level. Refills not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of that drug. Exceptions may apply. For a list of current drugs that are exempt from this Mail-Order requirement, refer to the 'Non-Specialty Drug List – Exempt from Mail-Order' available on BJCtotalrewards.org or you can log in at express-scripts.com.

You still have the option of filling non-specialty new prescriptions (first fills) through the Family Care Central Pharmacy, any BJC Pharmacy, or any Select Out-of-Area Pharmacy (SOOA) at the lowest copayment for that specific medication. A new prescription (first fill) can also be filled at an Express Scripts Participating Walgreens Pharmacy at a higher copayment.

ALL prescriptions for Specialty Drugs need to be directed to the Family Care Central Pharmacy. This includes new prescriptions (first fills) and refills. Prescriptions not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of the drug. Exceptions may apply. For a list of current drugs that are exempt from this Mail-Order requirement, refer to the 'Specialty Drug List – Exempt from Mail-Order' available on BJCtotalrewards.org or you can log in at express-scripts.com.

Prior Authorizations and Drug Quantity Limits

Prior Authorization for Specialty Drugs

ALL prescriptions for Specialty Drugs need to be directed to the Family Care Central Pharmacy. This includes new prescriptions (first fills) and refills. Prescriptions not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of the drug.

SaveonSP Savings Program for Specialty Drugs

Certain specialty drugs that are not considered "essential health benefits" will be covered with no copay or other cost to you if you participate in the SaveonSP Savings Program offered through Express Scripts using a third-party vendor. Instead, the copay will be paid by the drug manufacturer through its copay assistance program. The pharmacy will notify you when the program is available for your prescription and how to enroll in the program. If you do not enroll, you will be responsible for the copay which may be significant. Regardless of whether you pay the copay, or the copay is paid through the SaveonSP Savings Program, the copay will not count towards your annual out-of-pocket maximum or your deductible.

Prior Authorization for Certain Drugs

Certain drugs require prior authorization from Express Scripts. To obtain authorization for any of the drugs listed below, your doctor should call Express Scripts toll-free at 1-888-256-6132 (pharmacist/physician phone number) prior to seeking coverage for your prescription. If you do not obtain prior authorization when required, Express Scripts will notify the pharmacist that prior authorization is required before the prescription can be filled. The pharmacist can initiate the process on your behalf with your approval, but this may delay the time it takes you to receive your prescription.

Drugs requiring prior authorization include, but are not limited to: certain injectable drugs, certain oncology medications and compounded drugs that exceed $300. The Plan may revise this list and criteria at any time.

Step Therapy

In some cases, use of an alternative generic drug may be required before use of a higher cost brand drug. If you have already used the alternative generic, your physician may request an exception by contacting Express Scripts at 1-888-256-6132. Examples of medications that may require step therapy are oral brand name tetracyclines, topical brand name antifungals and select other medications.

Quantity Limits

In some cases, the Plan limits the quantity for certain medications—even though the copayment is the same. These limits are based on widely accepted clinical guidelines for the safe use of these types of medication. The list of drugs subject to these special quantity limits can be found on BJCtotalrewards.org, by contacting Express Scripts at 1-866-273-5779, or by logging in as a BJC member at express-scripts.com. The Plan may revise this list and guidelines at any time.

Emergency Fill Program

BJC HealthCare's pharmacy program allows you and your covered dependents to fill up to two (2) prescriptions at the BJC pharmacy level of copayment from a list of eligible drugs (Emergency Drug List) at an Express Scripts Participating Walgreens Pharmacy when BJC and Select Out-of-Area pharmacies are not available. Members getting these drugs will pay the regular BJC copayment for the first two (2) fills each Plan Year only. In addition, you do not need to obtain these medications through the Family Care Central Pharmacy; you may take these prescriptions to a BJC Pharmacy, Select Out-of-Area Pharmacy or an Express Scripts Participating Walgreens Pharmacy and pay the applicable copay. BJC HealthCare's Emergency Fill Drug List of allowable prescriptions is posted on Express Scripts' website, express-scripts.com (members must log-in first), and on BJCtotalrewards.org. BJC HealthCare's Emergency Fill Drug List does not include every possible drug in each drug therapy class. If you have questions regarding a particular drug or coverage under the Plan, please contact Express Scripts at 1-866-273-5779, or a BJC Pharmacy.

Maintenance Medications

The maintenance drug copayment provision allows participants an additional benefit for their maintenance prescription needs. Participants who take maintenance drugs included on the Maintenance Drug List specified by the Plan will pay less for a 90-day supply than if receiving three 30-day supplies. All 90-day supply prescriptions must be filled at the Family Care Central Pharmacy. To take advantage of the maintenance drug copayment, you must meet the following conditions:

- You must have a 90-day prescription from your doctor for the approved maintenance drug. However, depending on state pharmacy laws, certain maintenance drugs may be filled for a 90-day supply when only a 30-day prescription is written by your doctor. Please discuss this option with your pharmacist for detailed information regarding a 30-day versus 90-day supply.
- You must fill your 90-day prescription at the Family Care Central Pharmacy (90-day supplies are not available from other Pharmacies).

The maintenance copayment is another way the Plan saves you money, as described in the chart called 'Your Costs for a Maintenance Drug' below.

How the Plan Defines a Maintenance Drug

A maintenance drug is one that is included on the Plan's list of medications (Maintenance Drug List) that are used for treatment of long-term medical conditions and can be taken continuously and safely by a patient for a period of one (1) year or more. The Maintenance Drug List is periodically updated and is available on BJCtotalrewards.org or you can log in at express-scripts.com. The Plan may revise this list and criteria at any time.

Not All Long-Term Prescriptions Are "Maintenance Drugs"

Please note that not all prescriptions written for more than a 30-day supply qualify for the maintenance drug copayment under the Plan. You and your physician can find out which drugs qualify by consulting the Plan's Maintenance Drug List. It is possible that your doctor may prescribe a given drug for a long period of time, even though it is not on the list of approved maintenance drugs. In this case, your prescription will be limited to a 30-day supply per refill. Non-maintenance drugs do not qualify for the maintenance drug copayment.

YOUR COSTS FOR A MAINTENANCE DRUG (Family Care Central Pharmacy Only*)			
	Generic	**Preferred Brand-Name**	**Non-Preferred Brand-Name**
Three 30-Day Supplies (three visits)	$10 x 3 = $30	$30 x 3 = $90	$75 x 3 = $225
90-Day Supply (one visit)	$25	$75	$150
Your Savings	**$5**	**$15**	**$75**

*The maintenance drug copayment incentive is available only from the Family Care Central Pharmacy for ALL Refills. For Express Scripts Participating Walgreens Pharmacies, each fill on a prescription is limited to a 30-day supply.

Refill Rule

ALL REFILLS in Missouri and Illinois need to be filled through the Family Care Central Pharmacy; refills not processed through the Family Care Central Pharmacy will result in you paying the entire discounted cost of the drug. Exceptions may apply. You still have the option of filling non-specialty new prescriptions (first fills) through the Family Care Central Pharmacy, any BJC Pharmacy, or any Select Out-of-Area Pharmacy (SOOA) at the lowest copayment for that specific medication. A new prescription (first fill) can also be filled at an Express Scripts Participating Walgreens Pharmacy at a higher copayment.

Pharmacy Exclusions

The following drugs or types of drugs are excluded from coverage under the Plan:

- Any drug sought by a participant that given the circumstances is identified as **abusive, fraudulent, or wasteful**.
- **Anorexiants** (except those used for narcolepsy or hyperactivity).
- **Botox**.
- Any drug that does not satisfy or exceeds any **case management program** of the Plan, including without limitation, the Plan's opioid case management program.
- **Compound** medications (unless an exception applies).
- Therapeutic **devices or appliances**, support garments and other non-medicinal substances and disposable medical supplies, except Novopen for insulin and insulin syringes.
- Prescriptions for any outpatient drug in **excess of a 90-day supply**.
- Any drug provided by, or while the person is an **inpatient** in, any health care facility
- **Investigational or experimental drugs**, including compounded medications for non-FDA approved uses, and any drugs that are not medically necessary or not used in accordance with generally accepted medical practice.
- Any drug that is **self-prescribed** by a Participant doctor if self-prescription is prohibited by federal or state law or regulation or by rule of any regulatory body.
- Replacement of **lost, stolen, or damaged** prescriptions. Prescription drugs **for procedures and services** that are **not covered** services under the medical plan

- Drugs purchased from **non-participating pharmacies** (those that do not participate in the Plan).
- Any drug provided on any **outpatient basis in any health care facility** to the extent benefits are payable for it under any other part of the Plan, or under any other medical or prescription drug benefit plan carried or sponsored by BJC HealthCare.
- **Over-the-counter (non-prescription) drugs** other than insulin, diabetic supplies, certain contraceptives, certain smoking-cessation products, and others specifically covered by the Plan and prescribed by your physician.
- Certain prescription products (e.g., topical acne medications, cough/cold medications) that have **over-the-counter equivalents.**
- Any **refill dispensed more than one year from the date** of the latest prescription order; or as otherwise permitted by applicable law of the jurisdiction in which the drug is dispensed.
- Any **refill in excess** of the amount specified by the prescription order. Before the prescription can be covered, the Plan may require a new prescription, or evidence as to need, if a prescription or refill appears excessive under accepted medical practice standards.
- Prescription **refills that are attempted too soon** (prior to the time at which a refill would reasonably be expected based on the supply previously dispensed and the frequency and dosage recommended).
- **Rogaine** or other medication used to promote hair growth.
- **Unit-dose packaging** or special packaging required for medications that are administered in a nursing home or other facility. **Unit-dose packaging** for convenience also is excluded.
- Prescriptions that an eligible person is entitled to receive without charge under any **workers' compensation law**, or any municipal, state, or federal program.

Pharmacy Locations

BJC Pharmacy Locations

The following is a list of the BJC Employee Mail-Order, BJC Hospital Outpatient and BJC Health Center Pharmacies. For updated hours: https://www.bjctotalrewards.org/Benefits/Prescription-Drugs/Pharmacy-Types-and-Locations.

Family Care Central Pharmacy (Mail-Order Pharmacy)

Mail Order only; Closed to walk-in traffic (For new prescriptions and refills)
Phone: 314-657-9000 / 855-525-0411 or www.bjcrx.org

Family Care at Pharmacy at Barnes-Jewish Hospital
In the Center for Advanced Medicine Building, 3rd Floor
4921 Parkview Place, St. Louis, MO 63110
Phone: 314-657-9006 or 800-503-2298, Fax: 314-454-5399, or www.bjcrx.org

Family Care Pharmacy at Alton Memorial Hospital
#1 Memorial Drive, Room G247, Alton, IL 62002
Phone: 314-657-9001, Fax: 618-463-7884, or www.bjcrx.org

Family Care Pharmacy at Christian Hospital NE
11125 Dunn Road, St. Louis, MO 63136
Phone: 314-657-9002, Fax: 314-653-4431, or www.bjcrx.org

Family Care Pharmacy at Missouri Baptist Medical Center (MBMC)
3023 N. Ballas Road, Suite 100D, St. Louis, MO 63131
Phone: 314-657-9008, Fax: 314-996-7502, or www.bjcrx.org

***BJC Home Infusion Services** (designated only for infusion services)

***St. Louis Children's Hospital Specialty Care Center Pharmacies** (designated only for discharge prescriptions)

***BJC Behavioral Health Pharmacy** (designated only for discharge prescriptions)

***BJC Behavioral Health Southeast Pharmacy** (designated only for discharge prescriptions)

***St. Louis Children's Hospital Outpatient Pharmacy** (designated only for discharge prescriptions)

***** Indicates a BJC Pharmacy designated only for discharge prescriptions or infusion services.

Select Out-of-Area Pharmacy Locations

The following is a list of Select Out-of-Area Pharmacies. This list may change from time to time. For a current list, you may contact Express Scripts.

Walgreens
6 E. Springfield Road, Sullivan, MO 63080
Phone: 573-468-6464, Fax: 573-468-3809

Walgreens
600 W. Karsch Blvd., Farmington, MO 63640
Phone: 573-747-1591, Fax: 573-747-0761

Walgreens
1142 N. Desloge Drive, Desloge, MO 63601
Phone: 573-431-2242, Fax: 573-431-4799

Walgreens
5890 North Belt West, Belleville, IL 62226
Phone: 618-277-4440, Fax: 618-277-5857

Wal-Mart Store #65 Pharmacy
350 Parkridge Road, Sullivan, MO 63080
Phone: 573-468-5121, Fax: 573-468-5126

Wal-Mart Store #0317 Pharmacy
201 N. Mattes Ave., Vandalia, IL 62471
Phone: 618-283-0440, Fax: 618-283-9496

Participating Walgreens Pharmacy Locations

To find an Express Scripts Participating Walgreens Pharmacy location call Express Scripts customer service toll-free at 1-866-273-5779 or log on to express-scripts.com and use the Pharmacy Locator to find nearby pharmacies that participate in the BJC pharmacy program.

Pharmacy Claims Procedures

To receive benefits, simply present the medical/pharmacy ID card of the covered individual at a participating pharmacy. You should inform the pharmacy of your BJC prescription drug coverage when you order a prescription. This allows the pharmacy to handle the administrative process before you arrive at the pharmacy to pick up the prescription.

Be sure to have the medical/pharmacy ID number of the employee who carries the coverage and your medical/ pharmacy ID card with you when you go to a participating pharmacy. The medical/pharmacy ID identifies you and your dependents as participants in the Plan and provides the pharmacist access to information regarding the benefits to which you are entitled.

Prescription drop-off boxes are available at some pharmacy locations and can be used when the pharmacy is closed or very busy. Your pharmacy service offers other convenient features including:

- Next-day delivery from participating BJC Pharmacies (check with your BJC Pharmacy about delivery and mailing charges).
- Interactive voice response (IVR) system where you can reorder medications, check the status of prescription orders, and leave messages for pharmacy personnel.
- Interactive web access to refill prescriptions and send messages to pharmacy personnel.

Filing a Claim

Generally, you should not have to file any claims. However, in some situations you may be asked to pay the full cost of the medicine up front, for example, if you do not have your medical/pharmacy ID card. In this case, you will need to submit a claim to Express Scripts. The claim form and instructions are available on the BJC Total Rewards website. Alternatively, you may be able to return to the pharmacy location for a refund (contact the pharmacy to confirm).

If you are a new hire or otherwise have a problem with your medical/pharmacy ID when purchasing medicine, you should contact Express Scripts immediately.

IMPORTANT NOTICE FROM BJC HEALTHCARE ABOUT YOUR PRESCRIPTION DRUG COVERAGE AND MEDICARE

NOTE: If you and your family members are not eligible for Medicare and will not become eligible for Medicare within the next twelve (12) months, this notice does not apply to you.

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with BJC HealthCare and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

- Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
- BJC HealthCare has determined that the prescription drug coverage offered by the BJC HealthCare Medical and Dental Plan is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep the BJC coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can you Join a Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15th through December 7th.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens to Your Current Coverage If You Decide to Join a Medicare Drug Plan?

You are not required to enroll in a Medicare Part D drug plan at this time. If you do enroll in a Medicare drug plan, you and your eligible dependents will still be eligible to receive all of your current health and prescription drug benefits, subject to rules regarding coordination with Medicare.

If you do decide to join a Medicare drug plan and drop your current BJC HealthCare coverage, be aware that you and your dependents will not be able to get this coverage back unless you are still an active employee and you enroll during annual enrollment or have another qualified status change that would permit reenrollment during the year.

When Will You Pay a Higher Premium (Penalty) to Join a Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with BJC HealthCare and don't join a Medicare drug plan within sixty-three (63) continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go sixty-three (63) continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen (19) months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher

premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Drug Coverage…

Contact the BJC Benefits Department at: Mailstop 92-92-248, 8300 Eager Road, Suite 300C, St. Louis, MO 63144-1412 or at 314-362-0529.

NOTE: You will receive this notice each year, before the next period you can join a Medicare drug plan, and if BJC HealthCare prescription drug coverage changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit **www.medicare.gov**.
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help.
- Call 1-800-MEDICARE (800-633-4227). TTY users should call 877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at **www.socialsecurity.gov**, or call them at 800-772-1213 (TTY 800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date: September 30, 2021
Name of Entity: BJC HealthCare
Contact Position/Office: BJC Benefits Department
Address: Mailstop 92-92-248
8300 Eager Rd., Suite 300C, St. Louis, MO 63144-1412
Phone Number: BJC Benefits Department (314) 362-0529

DENTAL

Dental Options for BJC Employees

BJC offers two (2) dental coverage options from which to choose: the High Option and the Low Option. Both options are administered by Delta Dental of Missouri (DDMO). Dental care options are provided through two (2) networks of participating dental providers or you may receive care outside the networks at lower levels of reimbursement.

The following is a description of the coverage provided under each choice.

Schedule of Benefits - Dental for High and Low Options

	High			Low		
	Delta Dental PPO Network	**Delta Dental Premier Network**	**Non-Network**	**Delta Dental PPO Network**	**Delta Dental Premier Network**	**Non-Network**
Annual Deductible • **Individual** • **Family**	 $50 $100	 $50 No limit	 $50 No limit	 $75 $150	 $75 No limit	 $75 No limit
Preventive Care	100%; no deductible	100%; no deductible	80%; no deductible	100%; no deductible	100%; no deductible	60%; no deductible
Basic Care	80% after deductible	60% after deductible	60% after deductible	70% after deductible	60% after deductible	60% after deductible
Major Care	60% after deductible	40% after deductible	40% after deductible	50% after deductible	40% after deductible	40% after deductible
Orthodontia Benefit Services **Lifetime Maximum**	60% after deductible $2,000	40% after deductible $1,500	40% after deductible $1,500	No Coverage	No Coverage	No Coverage
Annual Maximum Benefit	$2,000	$1,500	$1,500	$1,000	$750	$750

The Deductible

There is no deductible for preventive dental care such as checkups, cleanings, and X-rays. For basic, major and orthodontia dental care, however, you pay a deductible before the Plan pays any benefits.

This deductible must be satisfied only once for each covered individual during any Plan Year. However, there is a special rule for the Delta Dental PPO Network benefits—if the sum of the basic, major and orthodontia dental care charges applied to the deductible for the covered members of your family totals the family deductible during one Plan Year, then no additional deductible will be required for the rest of that year for any family member. Delta Dental Premier Network and Out-of-Network (Non-Participating) benefits are not subject to this rule; each family member must pay the charges subject to the individual deductible for basic, major and orthodontia dental care provided by a Delta Dental Premier or Out-of-Network (Non-Participating) dental provider.

Annual and Lifetime Maximums

The annual maximum benefit shown above reflects the maximum benefit payable by the Plan for all covered charges, except orthodontia, per Plan Year for each covered individual.

Orthodontia benefits (payable only under the High Option) are subject to a separate lifetime maximum benefit of $2,000 for each covered individual if the charges are made by a Delta Dental PPO Network dental provider and $1,500 for charges made by a Delta Dental Premier or Out-of-Network (Non-Participating) dental provider.

For purposes of these maximum benefits, out-of-network benefits count toward the network maximums and network benefits count toward the out-of-network maximums.

Providers

Selecting Your Dentist

You may visit the Dentist of your choice and select any Dentist on a treatment by treatment basis. It is important to remember your out-of-pocket costs may vary depending on your choice. You have three (3) options.

1. **PPO Participating Dentist (Delta Dental PPO Network)**. Delta Dental's PPO Network consists of Dentists who have agreed to accept payment based on the applicable Delta Dental PPO Maximum Plan Allowance and to abide by Delta Dental policies. This Network offers you cost control and claim filing benefits.
2. **Non-PPO Participating Dentist (Delta Dental Premier Network)**. Delta Dental's Premier Network consists of Dentists who have agreed to accept payment based on the applicable Delta Dental Premier Maximum Plan Allowance. This Network also offers you cost control and claim filing benefits. However, your out-of-pocket expenses (deductibles and coinsurance amounts) may be higher with a Premier Dentist, based upon your plan design.
3. **Non-Participating Dentist (Out-of-Network)**. If you go to a non-participating Dentist (not contracted with a Delta Dental plan), DDMO will make payment directly to you based on the applicable Maximum Plan Allowance for the non-participating Dentist. It will be your obligation to make full payment to the Dentist and file your own claim. Obtain a claim form from DDMO.

Advantages of Selecting Participating Dentists

All participating Dentists (Delta Dental PPO and Delta Dental Premier) have the necessary forms needed to submit your claim. Delta Dental participating Dentists will usually file your claims for you and DDMO will pay them directly for covered services. Visit deltadentalmo.com to find out if your Dentist participates or contact DDMO to automatically receive, at no cost, a list of Delta Dental PPO and Delta Dental Premier participating Dentists in your area. You are not responsible for paying the participating Dentist any amount that exceeds the Delta Dental PPO or Delta Dental Premier Maximum Plan Allowance, whichever is applicable. You are only responsible for any non-covered charges, deductible and coinsurance amounts.

Claim Predetermination

If the care you need costs less than $200 or is emergency care, your Dentist will proceed with treatment upon your approval. If the cost estimate is more than $200 and is not emergency care, your Dentist will determine what treatment you need and could submit a treatment plan to DDMO for predetermination of benefits. This estimate will enable you to determine in advance how much of the cost will be paid by your dental coverage and how much you will be responsible for paying.

Covered Dental Services

Covered dental expenses include the Maximum Plan Allowance charges of a dental provider for the following services and supplies normally used for treatment of a dental condition:

Preventive Dental Services

- Oral examinations (evaluations), twice in any Plan Year (includes all types).
- Comprehensive oral examinations as required.
- Periapical x-rays as required.
- Bitewing x-rays as required.
- Full-mouth x-rays once in any 36-month period.
- Dental prophylaxis (cleaning, scaling, and polishing), twice in any Plan Year.
- Topical fluoride application for dependent children under age 19, once in any Play Year.
- Emergency palliative treatment as needed (minor procedures to temporarily reduce or eliminate pain).

- Space maintainers that replace prematurely lost teeth of eligible dependent children under age 19, once in five (5) years, except for accidental injuries.
- Sealants: for dependent children under age 19, limited to caries-free occlusal surfaces of the first and second permanent molars, once in any 36-month period.
- Two (2) additional cleanings are covered per Plan Year for patients who are pregnant, diabetic, have a suppressed immune system or have a history of periodontal therapy. To be eligible for the additional cleaning benefits, you must submit a completed Self-Report form, which can be obtained at deltadentalmo.com by clicking on the Healthy Smiles, Healthy Lives logo or by contacting customer service. If periodontal therapy has already been reported on your claims, the Self-Report form is not necessary.
- Brush biopsy to detect oral cancer

Basic Dental Services

- Restorative services using amalgam, synthetic porcelain, and plastic filling material. Composite fillings covered on all teeth.
- Periodontics: treatment for diseases of the gums and bone supporting the teeth. Periodontal surgery is covered only once in a 3-year period for the same site. Coverage for scaling and root planing are limited to once per 24 months.
- Endodontics: root canal filling and pulpal therapy (therapy for the soft tissue of a tooth).
- Simple extractions.
- Surgical extractions.
- Periodontal maintenance visits limited to twice in any Plan year (subject to your prophylaxis frequency limitation).
- Occlusal guard for bruxism and splint therapy, once in five (5) years.
- General anesthesia in conjunction with covered surgical procedures that are *Basic Dental Services*.
- Oral surgery.
- Consultations.

Major Dental Services

- Prosthetics: bridges and dentures, once in five (5) years.
- Crowns, jackets, labial veneers, inlays, and onlays when required for restorative purposes and when teeth cannot be restored with a filling material, once in five (5) years.
- General anesthesia in conjunction with covered surgical procedures that are *Major Dental Services*.
- Implants, as well as bone grafts, are a covered benefit. Limited to once in five (5) years per tooth. Please contact Delta Dental for additional details or view the *Dental Implants* section below.

Orthodontic Care (covered under the High Option only)

Orthodontic diagnostic procedures and treatment for correction of malposed teeth to establish proper occlusion through movement of teeth or their maintenance in position are covered for both adults and dependent children. This includes appliance therapy and functional/myofunctional therapy (excluding related oral examinations, surgery, and extractions). No benefits will be paid for repair or replacement of an orthodontic appliance. If coverage is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.

Dental Implants

The BJC HealthCare dental Plan options provide coverage for dental implants under the *Major Dental Services* level of coverage.

You may contact Delta Dental of Missouri for the current list of procedure codes that are covered under the Plan and can then provide this list to your Dentist, so he/she can better understand what implant procedures are covered and not covered. This list is also available to dental providers if they contact Delta Dental of Missouri on your behalf.

As always, it is highly recommended that your provider requests a "Predetermination of Benefits" before beginning any major dental services. This will help you and your Dentist understand what you will pay and what the Plan will pay for any given procedure.

Dental Plan Exclusions and Limitations

Coverage Limitations

- Endodontic (root canal treatment) on the same tooth is covered only once in a two (2) year period. Re-treatment of the same tooth is allowed when performed by a different dental office.
- Charges for replacement of filling restorations are only covered once in a 24-month period, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.
- If an existing bridge or denture cannot be made satisfactory, a replacement will be covered only once in five (5) years.
- Dental benefits for an initial or replacement crown, jacket, labial veneer, inlay or onlay on or for a particular tooth will only be provided once in five (5) years, unless the damage to that tooth was caused by accidental injury not related to the normal function of the tooth or teeth.
- If your membership is terminated before an orthodontic treatment plan is completed, coverage will be provided only to the end of the month of termination.
- Benefits will not be paid for repair or replacement of an orthodontic appliance.
- After completion of your orthodontic treatment plan or reaching your orthodontic lifetime maximum, no further orthodontic benefits will be provided.
- The benefits payable under the "High Option" with respect to a course of orthodontic treatment will be coordinated with the benefits received under another dental benefit option so that the total benefits received with respect to such course of treatment under both the High Option and another dental benefit option do not exceed the lesser of:

  (i) the total benefit that would be payable under the High Option for such treatment had such treatment started after coverage began, and

  (ii) the total benefit that would have been payable under the other option if such course of orthodontic treatment had concluded while coverage under that dental option remained in effect.

If you receive care from more than one (1) Dentist or service provider for the same procedure, benefits will not exceed what would have been paid to one Dentist for that procedure (including, but not limited to prosthetics, orthodontics, and root canal therapy). If alternative treatments are available, your coverage will only pay for the least costly professionally satisfactory treatment. This would include, but is not limited to, services such as composite resin fillings on molar teeth, in which case the benefits are based on the allowed amount for an amalgam (silver) filling; or services such as fixed bridges, in which case the benefits may be based on the allowed amount for a removable partial denture.

Services Not Covered

Charges for the following are not covered:

- Services or supplies for which you, absent this coverage, would normally incur no charge, such as care rendered by a Dentist to a member of his immediate family or the immediate family of his spouse.
- Services or supplies for which coverage is available under workers' compensation or employers' liability laws.

- Services or supplies performed for cosmetic purposes or to correct congenital malformations, except newborns with congenital dental defects.
- Services that require multiple visits, which commenced prior to the membership effective date (including prosthetics and orthodontic care).
- Services or supplies related to temporomandibular joint (TMJ) dysfunction (this involves the jaw hinge joint connecting the upper and lower jaws).
- Services or supplies not specifically stated as covered dental services (including hospital or prescription drug charges).
- Replacement of dentures and other dental appliances which are lost or stolen.
- Diseases contracted, or injuries or conditions sustained as a result of any act of war.
- Denture adjustments for the first six (6) months after the dentures are initially received. Separate fees may not be charged by participating Dentists.
- Tooth preparation, temporary crowns, bases, impressions, and anesthesia or other services which are part of the complete dental procedure. These services are considered components of and included in the fee for the complete procedure. Separate fees may not be charged by participating Dentists.
- Analgesia, including Nitrous Oxide, duplication of radiographs, temporary appliances, or related procedures.
- Services or supplies covered under a terminal liability, extension of benefits, or similar provision, of a program being replaced by this program.
- Services or supplies rendered by a dental or medical department maintained by or on behalf of a group, a mutual benefit association, union, trustee or similar person or group.
- Services or supplies provided or paid for by or under any governmental agency or program or law, except charges which the person is legally obligated to pay (this exclusion extends to any benefits provided under the U.S. Social Security Act, as amended).
- Services rendered beyond the scope of a Dentist's or service provider's license, or experimental or investigational services/supplies.
- Services or supplies that a Dentist determines for any reason, in his professional judgment, should not be provided.
- Instructions in dental hygiene, dietary planning, or plaque control.
- Missed appointments or claim form completion.
- Infection control, including sterilization of supplies and equipment.
- Complete occlusal adjustments, crowns for occlusal correction, athletic mouthguards, nightguards, and bite therapy appliances.

Treatment in Progress When Coverage Terminated

Benefits are payable in connection with the following services, if performed or delivered within three (3) months of the date on which coverage terminates:

- Root canal therapy if the tooth was prepared (opened) before coverage terminated.
- Dentures if the impressions were taken before coverage terminated.
- Fixed bridgework and restorations, including crowns, inlays and onlays, if the teeth which will serve as abutments, or which are being restored, were fully prepared and impressions were taken before coverage terminated.

Filing Dental Claims

When to File

If you are enrolled in either the Low or High option, you may have to submit a claim form to DDMO for your dental treatment, if treatment was provided by an out-of-network (Non-Participating) dental provider. Network (Delta Dental PPO) dental providers will submit claims directly to DDMO for you. Claims must be submitted by the end of the calendar year following the year in which services were rendered.

Where to File

Delta Dental will accept any universal claim form used by your dental provider. The completed claim forms and itemized bills should be sent to:

Delta Dental of Missouri
P.O. Box 8690
St. Louis, MO 63126-0690

Questions About Your Claim

If you do not understand or do not agree with the handling of a claim, there are several things that you can do to resolve the issue. Most of your questions can be answered by contacting Delta Dental of Missouri.

The contact information for Delta Dental of Missouri is:

314-656-3001, 1-800-335-8266 or deltadentalmo.com

You may also have the right to file an appeal. Please see the section of this SPD entitled *Claims Appeal Procedures - Medical/Pharmacy/Dental* under *Claims and Eligibility Appeals*.

Payment of Claims

Upon receipt of proof of a valid claim, any benefits due will be paid to the participating provider. In the event the provider is non-participating, the benefit will be payable to you or your beneficiary.

Glossary of Dental Terms

Course of Treatment

Course of treatment means a planned program of one or more services or supplies, rendered by one or more dental providers, for the treatment of a dental condition diagnosed by the attending dental provider as a result of an oral examination.

Dentist

A Dentist means a dentist duly licensed and legally qualified to practice dentistry at the time and place covered dental services are performed.

Experimental Services, Procedures or Supplies

Experimental Services, Procedures or Supplies means those services, procedures or supplies which in the opinion of the dental plan: 1) are not generally employed, utilized or recognized by a consensus of opinion by the dental community as being essential to the necessary dental care and treatment of the covered person's condition, 2) are of no proven or widely accepted therapeutic benefit to the covered person, or 3) are research or investigative studies or protocols.

Maximum Plan Allowance

Maximum Plan Allowance means the amount determined by the applicable Delta Dental Plan as the allowed amount for a particular procedure, service, or item for the particular Dentist or service provider. The allowed amount for a particular Dentist or service provider depends on its, his or her, participation status (i.e., DDMO PPO Dentist, DDMO Premier Dentist, or Non-Participating Dentist).

Necessary Dental Services

Necessary Dental Services means those dental services which are appropriate in terms of type, level, length and setting of service provided and represent the most cost-efficient delivery of services consistent with standards of good dental practice as determined by the dental plan. Two or more services may be suitable for the dental care of a specific condition, under standard dental practice. If a charge is incurred for one of those services, the dental plan may consider the charge to have been incurred for another less costly service which would have produced a professionally acceptable result, as determined by the dental plan.

Pre-operative X-rays or other diagnostic records may be requested to assist in this determination.

Orthodontic Care

Orthodontic Care means orthodontic treatment necessary for the prevention and correction of malocclusion.

Plan Year

A 12-month calendar year, beginning on January 1st and ending on December 31st of the same calendar year.

VISION

You choose the vision coverage you need for your family. You may elect vision coverage, or you may choose not to elect vision coverage. Vision insurance coverage is offered through Vision Service Plan (VSP).

Coverage Categories

For vision, you can select coverage for yourself and any of your eligible dependents as described in the Health Care Benefits: Eligibility and Enrollment section.

To cover a dependent for vision benefits, you must also elect that same coverage for yourself.

Network Benefits: Lens options (tints, scratch resistance coating, etc.) are available to you at VSP's member preferred pricing. If you choose a frame valued at more than your allowance, you will save 20% on the out-of-pocket costs for your frames.

Your employer does not contribute toward the cost of this vision care coverage.

Schedule of Benefits--Vision

VSP Provider Network: VSP Signature

Vision Plan Coverage Schedule of Benefits			
Benefit	**Description**	**Copay**	**Frequency**
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness • **KidsCare**: Children have two, fully covered WellVision exams, if needed	$15	Every calendar year
Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat $20 per exam immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more. • Coordination with your medical coverage may apply. Ask your VSP doctor for details	$0 per Screening $20 per exam	Available as needed

Prescription Glasses		$15	See frame and lenses
Frame	• $200 allowance for a wide selection of frames • $220 allowance for featured frame brands • 20% savings on the amount over your allowance • $110 Costco® and Walmart frame allowance • **KidsCare**: Frames & lenses available once every calendar year. • Additional lenses covered-in-full when needed	Included in Prescription	Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • KidsCare: Frames & lenses available once every calendar year. • Additional lenses covered-in-full when needed	Included in Prescription Glasses	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 35-40% on other lens enhancements	$0 $80 - $90 $120 - $160	Every calendar year

Contacts (instead of glasses)	• $200 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) After the $60 copayment the full $200 allowance is available to use towards the cost of contacts.	Up to $60	Every calendar year

Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 30% savings on additional glasses and sunglasses, including lens enhancements, from the same VSP provider on the same day as your WellVision Exam. Or get 20% from any VSP provider within 12 months of your last WellVision Exam.
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor

Your Coverage with Out-of-Network Providers		
Get the most out of your benefits and greater savings with a VSP network doctor. Your coverage with out-of-network providers will be less or you will receive a lower level of benefits. Visit vsp.com for plan details.		
Exam..... up to $45	Lined Bifocal Lenses ..... up to $65	Progressive Lenses..... up to $85
Frame ..... up to $47	Lined Trifocal Lenses ..... up to $85	Contacts..... up to $105
Single Vision Lenses..... up to $45		
Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and BJC's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., Is the legal name of the corporation through which VSP does business.		

Providers

VSP Providers - Network Care

If you want vision care from a VSP participating provider, you must identify yourself as a VSP member at the time you schedule your appointment. When you call, the VSP participating provider will also need to know the first and last name and date of birth of the covered employee. The provider will use this information to confirm your eligibility and obtain authorization from VSP to treat you. If you fail to provide this information, you may be treated as having received benefits from a non-VSP provider.

If you need assistance in locating a VSP participating provider, you may call VSP at 1-800-VSP-7195 (1-800-877-7195) or go to vsp.com. VSP can mail you a copy if you do not have access to a computer.

If you obtain services from a VSP provider, VSP will pay the provider directly. You pay only a copayment for each examination and an additional copayment for eyeglasses. You are responsible for the cost of any additional services such as tints, coated lenses, progressive lenses, etc., or the cost of a frame over the VSP allowance. The majority of frames available are covered. If you purchase contact lenses, you pay the amount of the cost in excess of the VSP allowance shown in the schedule of benefits.

Non-VSP Providers (Out-of-Network) Care

You may obtain vision services from any licensed vision provider, although using non-VSP providers will affect the claims procedure and the amount of benefits you receive. When you receive your vision care from a non-VSP provider, you pay the provider's charge at the time of service, and you must file a claim with VSP within one hundred eighty (180) days of the date services were provided. VSP will then reimburse you for the charges (minus the copayments), up to the out-of-network maximum amount.

For example, if you receive an eye examination from a non-VSP provider who charges $50, you will be reimbursed $35 ($50 reduced by the $15 copayment). The maximum reimbursement allowed in this example is $45.

Covered Vision Services

Contact Lenses

The Plan provides benefits for both necessary and elective contact lenses. You may obtain contact lenses from either VSP or non-VSP providers. Note that you are entitled to receive a discount of 15% off the cost of elective contact lens examination services if you use a VSP network provider.

Elective Contacts

Contact lenses are considered elective when your vision could be corrected with glasses, but you choose contact lenses instead. An allowance will be paid toward the contact lens evaluation fee, fitting costs, and materials in lieu of the benefits outlined under “Eyeglass Lenses and Frames” below. In other words, you may receive one (1) pair of glasses or contacts - not both - in a calendar year.

Necessary

Contacts are considered necessary when they are prescribed for any of the following conditions:

- Certain conditions of anisometropia
- Following cataract surgery
- Keratoconus
- To correct extreme visual acuity problems that can’t be corrected with regular lenses

Cosmetic Extras

Certain cosmetic extras are not covered by the Plan but may be available at reduced prices from VSP providers when a complete pair of glasses is dispensed. These include:

- Anti-reflective coatings, color coating, mirror coating, scratch coatings
- Blended lenses
- Certain limitations on low vision care
- Cosmetic lenses
- Laminated lenses
- Optional cosmetic processes
- Oversize lenses
- Photochromic lenses; tinted lenses except Pink #1 and Pink #2
- Polycarbonate lenses covered for children when obtained from a network provider
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses

Eyeglass Lenses and Frames

If the vision exam indicates that new lenses, or frames, or both are necessary for proper visual health, they will be prescribed.

Each covered person is entitled to new lenses every calendar year and new frames every other calendar year, up to the maximum benefit provided in the *Schedule of Benefits--Vision*. However, you may receive one (1) pair of glasses or contacts - not both - in a calendar year.

Some brands of spectacle frames may be unavailable for purchase as Plan benefits or may be subject to additional limitations. You and your covered dependents may obtain details regarding frame brand availability from your VSP provider or by calling VSP at (800) 877-7195.

Low Vision Benefits

The Plan will pay benefits for covered services for persons with severe visual problems that are not correctable with regular lenses. If your doctor suspects a low vision condition, notice must be sent to Vision Service Plan’s Board for approval. If the Board agrees with the initial assessment, it may authorize supplemental testing by the doctor. This testing would be to determine the nature of the problem and to allow the doctor to gather enough facts to propose a treatment plan. (If you use a VSP provider, VSP pays all costs for the supplemental testing.) Once testing and treatment plans have been submitted and Board approved, VSP will authorize low vision benefits paying 75% of the cost—you

pay the other 25% of covered charges. VSP will pay a maximum amount of $1,000 every two (2) calendar years for this benefit. Examples of charges that may be covered are magnifying glasses and fiche machines.

You may receive these low vision services from any licensed provider; however, the benefits payable for non-VSP provider services will be limited to the amount that would have been paid to a VSP provider. If you use a non-VSP provider, you will need to pay the provider and then submit a claim to VSP for reimbursement.

Necessary Professional Services

Necessary professional services related to lenses and frames are also covered. These include, but are not limited to:

- Assisting in frame selection
- Fitting and adjustment of the frames
- Prescribing and ordering proper lenses
- Progress or follow-up work as necessary
- Subsequent adjustments to frames to maintain comfort and efficiency
- Verifying that the finished lenses are accurate

Vision Examination

You and each of your covered dependents are entitled to a complete vision examination once each calendar year. There may be additional charges for a contact lens exam and fitting. Eligible dependent children may be entitled to two (2) vision examinations per calendar year, if needed.

Vision Exclusions

There is no benefit for professional services or materials connected with:

- Corrective vision treatment of an experimental nature;
- Costs for services and/or materials in excess of Plan benefit allowances;
- Medical or surgical treatment of the eyes;
- Orthoptics and vision training and any associated supplemental testing;
- Plano lenses (less than ±.50 diopter power);
- Replacement of lenses and frames furnished under this Plan which are lost or broken except at the normal intervals;
- Services/materials not indicated as covered Plan benefits; or
- Two (2) pair of glasses in lieu of bifocals.
- Contact lens insurance policies or service agreements.
- Refitting of contact lenses after the initial (90-day) fitting period.
- Services associated with Corneal Refractive Therapy (CRT) or Orthokeratology.

How to File a Vision Claim

Questions About Your Claim

If you do not understand or do not agree with the handling of a claim, there are several things that you can do to resolve the issue. Most of your questions can be answered by calling or writing VSP at the address below.

The telephone number for VSP is: 1-800-877-7195. You may also have the right to file an appeal. Please see the section of this SPD entitled *Claims and Grievance Procedures for Vision Coverage* under *Claims and Eligibility Appeals*.

Payment of Claims

Upon receipt of proof of a valid claim, any benefits due will be paid to you.

When and Where to File

If you use a VSP provider, the provider will file your claim for you. However, if your vision treatment was provided by a non-VSP provider, you will have to file a claim for reimbursement. You are not required to submit a claim form to request the reimbursement; you may send VSP your original receipts, invoices or other proof of loss (be sure to retain a copy for your records) and sufficient information about yourself so VSP may identify you (name and address). Claims must be submitted within one hundred eighty (180) days after the date the services were rendered.

Your claim should be sent to:

Vision Service Plan Insurance Company
P.O. Box 385018
Birmingham, AL 35238-5018.

CLAIMS AND ELIGIBILITY APPEALS

Eligibility and Enrollment Appeals

For questions and information regarding eligibility and enrollment, please consult the *Health Care Benefits Eligibility* and *Enrollment Process* sections of this SPD or contact the BJC Benefits department. If you are denied eligibility or enrollment, and believe that the denial is not justified, please submit a written appeal along with the reasons you believe that the denial was inappropriate and any other documentation that supports your position to:

BJC Plan Administrator
c/o BJC HealthCare Benefits Department
Mail Stop 92-92-248
8300 Eager Road, Suite 300C
St. Louis, MO 63144

Your appeal and all supporting documentation must be received by the BJC Plan Administrator within sixty (60) days of the date you or your dependent are determined to be ineligible or denied enrollment. The BJC Plan Administrator will respond to your appeal as soon as possible, but not later than sixty (60) days after its receipt.

Claims Appeal Procedures - Medical/Pharmacy/Dental

For purposes of this section, the term "Benefits Manager" shall mean Cigna HealthCare for medical and mental health and substance abuse claims, Express Scripts for the *Pharmacy Program*, and Delta Dental of Missouri for dental benefits. As some provisions do not apply to all of the Benefits Managers, exceptions to this definition will be described in this section, as applicable.

There are three (3) types of claims for benefits, each of which is subject to different rules.

- A pre-service claim is a claim for a benefit that requires prior approval under the terms of the Plan, such as inpatient admissions or medications, which require prior authorization.
- An urgent care claim is a type of pre-service claim which, if the regular time periods for handling pre-service claims were followed: (1) could seriously jeopardize your life or health or your ability to regain maximum function; or (2) would, in the opinion of a health care provider with knowledge of your condition, subject you to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim.
- A post-service claim is a claim for a benefit that does not require prior approval under the terms of the Plan. A post-service claim involves a claim for payment or reimbursement for services that have already been received.

Submitting Claims

Pre-service and urgent care claims. A pre-service claim, including an urgent care claim, will be considered submitted when a request for prior authorization is received by the appropriate Benefits Manager.

Incorrectly submitted claims. If the Plan's procedures for filing a pre-service claim are not followed, you or your health care provider will be notified of the appropriate procedures if: (1) the request for prior approval was received by someone who customarily is responsible for handling benefit matters, and (2) the communication identifies the claimant, the specific treatment, service or product for which approval is requested and the medical condition or symptom that is the basis for the request. Notice of an incorrectly submitted claim will be provided no more than twenty-four (24) hours (for urgent care claims) or five (5) calendar days (for all other pre-service claims) after the incorrectly submitted claim is received. This notice may be oral unless you request written notification.

Post-service medical and dental claims. Typically, network providers will submit claims directly to the appropriate Benefits Manager and you will only be required to pay the applicable deductible and/or copayment. However, when you are required to pay a health care provider for covered services, such as when you receive care from an out-of-network provider, you should submit a request for reimbursement for such services in writing to the appropriate Benefits Manager within twelve (12) months after the date those services were rendered.

Post-service pharmacy claims. Participating pharmacies generally will be paid directly by Express Scripts and no claim for benefits is involved. There is no pharmacy benefit outside of the network of participating pharmacies in the Plan. However, sometimes you may be required to pay for the services and submit a claim for reimbursement. This may occur, for example, if you do not present your Member Identification Card with your prescription. You must pay the full cost of the drug and then apply for a refund of the amount in excess of the copayment. If this occurs, your application for the refund is the claim that triggers the application of the claims procedures described below.

If you must submit claims, what follows is information regarding where the claims should be sent and the number you can call with questions:

For medical and mental health and substance abuse claims:

Cigna HealthCare
P. O. Box 182223
Chattanooga, TN 37422-7223
Customer Service Phone: 1-800-244-6224

For pharmacy claims:

Express Scripts
Attn: Commercial Claims
P. O. Box 14711
Lexington, KY 40512-4711
Phone: 1-866-273-5779

For dental claims:

Delta Dental of Missouri Appeals Committee
12399 Gravois Road
St. Louis, MO 63127-1702

Initial Claims Determinations

The timeframes for making the initial decision regarding a claim and the procedures for notifying you about that decision depends on the type of claim.

Determinations with respect to claims for services that require prior authorization shall be made as described within the timeframes described below.

Urgent care claims. You will be notified whether your urgent care claim has been approved or denied as soon as possible, but in no event later than seventy-two (72) hours after the claim is received. If more information is needed in order for a determination to be made, you will be advised of the specific information necessary to complete the claim within twenty-four (24) hours after receipt of the claim. You will be allowed at least forty-eight (48) hours to provide the necessary information. You will be notified of the determination within forty-eight (48) hours after the earlier of: (1) the Plan's receipt of the requested information, or (2) the end of the period you were given in which to provide the information. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Pre-service claims. You will be notified whether your pre-service claim has been approved or denied within a reasonable period of time appropriate to the medical circumstances involved, but in no event more than fifteen (15) days after the claim is received. The 15-day period may be extended an additional fifteen (15) days if the extension is necessary due to matters beyond the control of the Benefits Manager and you are notified of the extension before the

initial 15-day period expires. If the extension is required because you failed to submit information necessary to decide the claim, the extension notice will specifically describe the information needed to complete the claim. You will be given at least forty-five (45) days from the time you receive the notice to provide the requested information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

- If a Benefits Manager previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments and you wish to extend the course of treatment beyond that which had been approved, you may request an extension. If the claim involves urgent care, you will be notified whether the extension has been approved or denied no more than twenty-four (24) hours after your request for the extension is received, provided that you make such request at least twenty-four (24) hours before the end of the previously approved period of time or before you received all of the previously-approved treatments. If the request for an extension is made less than twenty-four (24) hours before the expiration of the prescribed period of time or number of treatments, the request will be treated as a new urgent care claim and decided under the general timeframe applicable to urgent care claims. If the claim does not involve urgent care, the extension request will be treated as a new pre-service claim and will be decided within the timeframe applicable to pre-service claims as described earlier.
- If the Benefits Manager previously approved an ongoing course of treatment that was to be provided over a period of time or that involved a specified number of treatments, any decision by the Plan to reduce or terminate that course of treatment (other than by plan amendment or termination) before the end of such period of time or before all approved treatments have been received will be considered a benefit denial. You will be notified sufficiently in advance of such reduction or termination to allow you to appeal and obtain a determination on the appeal before the benefit is reduced or terminated.

Post-service claims. The applicable Benefits Manager will decide a post-service claim within a reasonable period of time, but not later than thirty (30) days after the claim is received. This time period may be extended for an additional fifteen (15) days when necessary due to matters beyond the control of the Benefits Manager or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than forty-five (45) days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will specifically describe the information needed to complete the claim and you will be allowed forty-five (45) days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to such notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

If Your Claim Is Denied

If your claim for a benefit is denied in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the Plan's internal and, if applicable, an external review process, including the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered.
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
  - If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
    - A description of the specific rule, guideline, protocol, or criterion relied on, or

- A statement that a copy of such rule, guideline, protocol, or criterion will be provided free of charge upon request.

- If the basis for the denial was medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:

  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances, or

  - A statement that such an explanation will be provided free of charge upon request.

- In the case of a denial of an urgent care claim, a description of the expedited review process applicable to such claim.
- The following information will also be provided:
  - Sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code, treatment code and their corresponding meanings are also available upon request.
  - The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim.
  - The availability of, and contact information for, as applicable office of health insurance consumer assistance or ombudsman established under the PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

Review of Denied Claims

You have one hundred eighty (180) calendar days after receiving notice that your claim has been denied in whole or in part in which to appeal the determination.

If you fail to file an appeal within one hundred eighty (180) days, you shall be deemed to have waived any right to appeal the denial of the claim. You are entitled to a full and fair review of the claim and the denial, which means:

- You may submit written comments, documents, records, and other information relating to the claim for benefits;
- You may obtain upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits;
- You will have the opportunity to review the claim file and present evidence and testimony;
- If the Benefits Manager (i) considers, relies upon or generates any new evidence in connection with the claim, or (ii) bases an appeal decision on any new or additional rationale, the Benefits Manager will provide the evidence or rationale to you, free of charge and sufficiently in advance of its decision deadline to give you a reasonable opportunity to respond before that deadline;
- The review will take into account all comments, documents, records, and other information you submit, without regard to whether such information was submitted or considered with respect to the initial claim;
- The review will be conducted by someone who is neither the individual who made the initial determination, nor the subordinate of such individual;
- In the case of an appeal involving medical judgment, the Benefits Manager will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual who was consulted on the initial claim determination, nor the subordinate of such individual; and
- Any medical or vocational experts whose advice was obtained in connection with the initial determination will be identified, regardless of whether the advice was relied upon in the initial determination. Appeals of decisions must be submitted to the appropriate Benefits Manager at the following addresses. Your appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate.

For medical and mental health and substance abuse claim appeals:

Cigna HealthCare
P. O. Box 188062
Chattanooga, TN 37422-8062
Customer Service Phone: 1-800-244-6224

For pharmacy clinical appeals:

Express Scripts.
Attn: Clinical Appeals Department
P.O. Box 66588
St. Louis, MO 63166-6588
Phone: 1-800-753-2851
Fax: 1-877-852-4070

For pharmacy administrative appeals:

Express Scripts
Attn: Administrative Appeals Department
P.O. Box 66587
St. Louis, MO 63166-6587
Phone: 1-800-946-3979
Fax: 1-877-328-9660

For dental claim appeals:

Delta Dental of Missouri Appeals Committee
12399 Gravois Road
St. Louis, MO 63127-1702

Except in the case of an appeal involving an urgent care claim, your appeal must be in writing. If you do not file an appeal within this time period, you will lose the right to appeal the determination.

Expedited procedures for urgent care claims: You may request an expedited appeal of a denial involving an urgent care claim. This request may be oral or in writing. Under these expedited procedures, all necessary information, including the determination on appeal, may be transmitted to and from the Benefits Manager by telephone, facsimile or other available similarly expeditious method. The phone number for initiating an expedited appeal is provided above.

Timeframes for Medical, Pharmacy and Dental Claims Appeals

In this subsection, "Benefits Manager" refers to Cigna HealthCare for medical and mental health and substance abuse treatment claims, Express Scripts for pharmacy claims, and Delta Dental of Missouri for dental claims.

The timeframe for making a decision on the appeal depends on the type of claim:

Urgent care appeals. In the case of an urgent care claim, the appropriate Benefits Manager will notify you of the determination on appeal as soon as possible, taking into account the medical urgency of the situation, but in no event more than seventy-two (72) hours after your appeal is received by the Benefits Manager.

Pre-service appeals. The appropriate Benefits Manager will review and decide your appeal within a reasonable period of time but no longer than fifteen (15) days after it is submitted. If you are not satisfied with the decision of the Benefits Manager, you have the right to file a second level appeal with the Benefits Manager for medical and mental health and substance abuse appeals, the Benefits Manager for pharmacy appeals, or the Plan Administrator for dental appeals, sent in care of the appropriate Benefits Manager. Your second level appeal request must be submitted within sixty (60) days from receipt of the first level appeal decision and must be in writing. Appeals must be submitted to the appropriate Benefits Manager at the address shown for that Benefits Manager for final determination. Dental appeals will be

forwarded, along with any information that the Benefits Manager has regarding the first level appeal, to the BJC Plan Administrator for final determination.

A determination will be made by the Benefits Manager or Plan Administrator, as applicable, no more than fifteen (15) days after your second level appeal is received.

Post-service appeals. The appropriate Benefits Manager will review and decide your appeal within a reasonable period of time but no later than thirty (30) days after it is received. If you are not satisfied with the decision of the Benefits Manager, you have the right to file a second level appeal with the Benefits Manager for medical and mental health and substance abuse appeals, the Benefits Manager for pharmacy appeals, or the BJC Plan Administrator for dental appeals, in care of the appropriate Benefits Manager. Your second level appeal request must be submitted within sixty (60) days from receipt of first level appeal decision and must be in writing. Appeals must be submitted to the appropriate Benefits Manager at the address shown for that Benefits Manager for final determination. Dental appeals will be forwarded, along with information that the Benefits Manager has regarding the first level appeal, to the BJC Plan Administrator for final determination.

A determination will be made by the Benefits Manager or Plan Administrator, as applicable, no more than thirty (30) days after your second level appeal is received.

Determinations on Appeal for Medical, Pharmacy and Dental Claims

The review at each level of appeal will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination or at a lower level of appeal. The review will not give deference to the initial denial or to the decision at a lower level of appeal. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim or made a decision at a lower level of appeal and will not be that individual's subordinate.

A health professional may be consulted in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination or at a lower level of appeal nor be a subordinate of the health professional who was involved.

Except in instances in which notice is provided pursuant to the expedited procedures for urgent care appeals described earlier, you will be notified in writing of the decision on appeal. If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific Plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances; or
  - A statement that such an explanation will be provided free of charge upon request.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol, or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol, or criterion will be provided free of charge upon request.
- A statement of your right to bring a civil action under Section 502 of ERISA.

For medical and pharmacy claims appeals only, the following information will also be provided:

- A description of the Plan's external review process.
- Sufficient information to identify the claim involved, including the date of service, the health care provider, and the claim amount (if applicable). The diagnosis code, the treatment code and their corresponding meanings are available upon request.

- The denial code and its corresponding meaning, as well as a description of the Plan's standard, if any, that was used in denying the claim, and a discussion of the decision.
- The availability of, and contact information for, as applicable office of health insurance consumer assistance or ombudsman established under the PHS Act section 2793 to assist individuals with the internal claims and appeals and external review processes.

The decision of the applicable Benefits Manager (for all medical and non-urgent pharmacy appeals or urgent dental appeals) or of the Plan Administrator (for urgent pharmacy appeals and non-urgent dental appeals) is final and binding on all individuals dealing with or claiming benefits under the Plan.

External Review After Exhaustion of Plan's Internal Appeals Process (Medical and Pharmacy Claims Appeals only - not applicable to Dental Claims Appeals)

In cases where a medical or pharmacy claim denial is upheld in whole or in part, through the internal appeals process above, you may submit an appeal to the external review process (the external review process is not available for dental claims denials). Please note, however, the external review process applies only to an adverse benefit determination that involves medical judgment, as determined by the medical reviewer, or that involves a rescission of coverage.

1. Request for External Review. File a request for an external review with the Medical Benefits Manager (including pharmacy claims) within four (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 (4) months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month 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 five (5) business days following the date of receipt of the external review request, the Medical or Pharmacy Benefits Manager shall complete a preliminary review of the request to determine whether:

   (a) You are or were covered under the Plan at the time the health care item or service was requested or, in the case of a retrospective review, were 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 your failure to meet the requirements for eligibility under the terms of the group health plan (e.g., worker classification or similar determination);

   (c) You have exhausted the Plan's internal appeal process, unless you are not required to exhaust the internal appeals process; and

   (d) You have 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 must issue a notification to you in writing. If the request is complete but not eligible for external review, such notification must 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, the written notification must describe the information needed to complete the request, and you shall be permitted to perfect the request for external review within the four-month filing period or within the forty-eight (48) hour period following the receipt of the notification, whichever is later.

3. Referral to Independent Review Organization. The Plan shall assign an independent review organization ("IRO") that is accredited by the Utilization Review Accreditation Committee ("URAC") or by a similar nationally-recognized accrediting organization to conduct the external review. The Plan will contract (either directly or indirectly through a third-party administrator) with the number of IROs required by law and rotate claims assignments among them (or incorporate other independent unbiased methods for selections of IROs such as random selection). The IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of benefits.

   (a) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review. This notice will include a statement that the claimant may submit in writing to the assigned IRO within ten (10) business days following the date of receipt of the notice, additional information that the IRO must consider when conducting the external review. The IRO is not required to but may accept and consider additional information submitted after ten (10) business days.

(b) Within five (5) business days after the date of assignment of the IRO, the Plan must provide to the assigned IRO the documents and any information considered in making the adverse benefit determination or final internal adverse benefit determination. Failure by the Plan to timely provide the documents and information must not delay the conduct of the external review. If the Plan fails to timely provide the documents and information, the assigned IRO may terminate the external review and make a decision to reverse the adverse benefit determination or final internal adverse benefit determination and provide coverage or payment. Within one (1) business day after making the decision, the IRO must notify the claimant and the Plan.

(c) Upon receipt of any information submitted by the claimant, the assigned IRO must within one (1) business day forward the information to the Plan. Upon receipt of any such information, the Plan may reconsider its adverse benefit determination or final internal adverse benefit determination that is the subject of the external review. Reconsideration by the Plan must not delay the external review. The external review may be terminated as a result of the reconsideration only if the plan decides, upon completion of its reconsideration, to reverse its adverse benefit determination or final internal benefit determination and provide coverage or payment. Within one (1) business day after making such a decision, the Plan must provide written notice of its decision to the claimant and the assigned IRO. The assigned IRO must terminate the external review upon receipt of the notice from the Plan.

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

(i) The claimant's medical records;

(ii) The attending healthcare professional's recommendation;

(iii) Reports from appropriate health care professionals and other documents submitted by the Plan or claimant or claimant's treating provider;

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

(v) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal Government National or Professional Medical Societies, Boards, and Associations:

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

(vii) The opinion of the IRO's clinical reviewer or reviewers after considering information described in this notice to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

(e) The assigned IRO must provide written notice of the final external review decision within forty-five (45) days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

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 immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

Expedited External Review Process
(Medical and Pharmacy Claims Appeals only - not applicable to Dental Claims Appeals)

The expedited external review process is only available for certain medical and pharmacy claims denials (and is not available for dental claim denials).

1. Request for Expedited External Review. The Plan shall allow you to make a request for an expedited external review if you receive:

(a) An adverse benefit determination if the adverse benefit determination involves a medical condition for which the timeframe for completion of an expedited internal appeal under the interim final regulations

would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function and you have filed a request for an expedited internal appeal; or

(b) A final internal adverse benefit determination, if you have a medical condition where the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function, or if the final internal adverse benefit determination concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but have not been discharged from a facility.

2. Preliminary review. Immediately upon receipt of the request for expedited external review, the Medical Benefits Manager (including pharmacy claims) shall determine whether the request meets the reviewability requirements described above for standard external review. The Medical Benefits Manager must immediately send to you a notice of its eligibility determination that meets the requirements set forth above for standard external review.

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 must 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, must consider the information or documents described above under the procedures for standard review. In reaching a decision, the assigned IRO must 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 contract with the assigned IRO must 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 seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice is not in writing, the assigned IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after the date of providing that notice.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. Generally, this authorization must be in writing and signed by you; however, in the case of an urgent care claim or appeal, a physician or other health care professional who is licensed, accredited, or certified to perform specified health services consistent with state law and who has knowledge of your medical condition will be acknowledged as your authorized representative even if no written designation is submitted. Any reference in these claims procedures to "you" is intended to include your authorized representative.

The designation of an authorized representative is not the same as either an assignment of benefits or an assignment of your right to pursue a claim or appeal, both of which are restricted as described below under "No Assignment." Any form that you sign at a health care provider's office or facility which purports to assign your benefits to the provider does not make the provider your authorized representative under these claims and appeals procedures. If you want the provider to be your authorized representative, you must complete a separate authorization form for that purpose unless the situation involves an urgent care claim or appeal as described above. These authorization forms may be obtained from the appropriate Benefits Manager.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant

first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

No Assignment

You cannot assign your benefits under the Plan. The Plan may pay benefits directly to a provider who has provided services to you regardless of whether you have executed an assignment of benefits or other directive. The Plan may also in its discretion pay benefits directly to you in which case you are responsible for paying the provider. You, or anyone acting on your behalf, may not assign your right to file a claim or an appeal under the Plan's claims and appeal procedures or your right to initiate any legal or other proceeding against the Plan, the Plan Administrator, or any Plan fiduciary.

Inquiry and Grievance Procedure for Non-Claim Medical Plan Issues

The purpose of the inquiry and grievance procedure is to address any matter that causes you to be dissatisfied with your coverage. You are encouraged to call the appropriate Benefits Manager's customer service department if you have any questions or concerns related to your coverage.

Inquiries

You may write or call the Benefits Manager to address any questions or concerns with a customer service representative. Representatives can respond immediately to most inquiries. If they cannot respond immediately, they will investigate and either respond to the inquiry or advise you that they will respond within ten (10) working days after the date of receipt of that inquiry.

Grievance Procedure

You may call or write to the appropriate Benefits Manager at:

For medical and mental health or substance abuse treatment benefits and provider issues:
Cigna HealthCare
P. O. Box 182223
Chattanooga, TN 37422-7223
Customer Service Phone: 1-800-244-6224

For pharmacy benefits and issues:
Express Scripts
Attn: Service Grievance Resolution Team
P.O. Box 3610
Dublin, OH 43016-0307
Fax: 614.907.8547

For dental benefits:
Delta Dental of Missouri
Attn: Grievance Committee
12399 Gravois Road
St. Louis, MO 63127-1702

If you are not satisfied with the representative's response to your inquiry, you may file a grievance. A grievance is a written complaint submitted by you or on your behalf regarding:

- the availability, delivery, or quality of health care services; or

- matters pertaining to the relationship between you and a provider.

The representative will acknowledge each grievance within ten (10) working days of receipt of the grievance and will conduct a complete investigation within twenty (20) working days of receipt of the grievance. If the investigation cannot be completed within twenty (20) working days after receipt of grievance, you will be notified in writing before the 20th day and the investigation will be completed within thirty (30) working days thereafter. The notice will state the reasons why additional time is needed for the investigation.

Within five (5) working days after the investigation is completed, someone not involved in the circumstances giving rise to the grievance or its investigation will decide upon the appropriate resolution of the grievance. You and your representative (if the grievance is submitted by a representative acting on your behalf), will be notified in writing, in clear and specific terms, of the Benefits Manager's resolution regarding the grievance and of any right to appeal.

If you are not satisfied with the initial response to the grievance, you may request a formal grievance review. The representative will notify you of the time, date, and place where the meeting will be conducted within five (5) working days after receiving a request for a meeting. The grievance advisory panel shall consist of other covered individuals and representatives of the Benefits Manager not previously involved in the grievance.

The meeting will be conducted within fifteen (15) working days after the notice of meeting is mailed to you. You will be advised of the procedures that will be followed during the meeting.

Claims and Grievance Procedures for Vision Coverage

Initial Claims Determinations

Vision Service Plan (VSP) will pay or deny claims within thirty (30) calendar days of the receipt of the claim from you or your authorized representative. VSP may, if necessary, extend the time for decision by no more than fifteen (15) calendar days if due to matters beyond the control of VSP or if your claim is incomplete. If the extension is needed because your claim is incomplete, you will be allowed forty-five (45) days to provide the necessary information. The timeframe for deciding the claim will be suspended until you respond to the request for more information. If you do not respond within forty-five (45) days, your claim will be decided without the requested information.

If Your Claim is Denied

If your claim for benefits is denied by VSP in whole or in part, VSP will notify you in writing of the reason or reasons for the denial. Within one hundred eighty (180) days after receipt of such notice of denial of a claim, you may make a verbal or written request to VSP for a full review of such denial. The request should contain sufficient information to identify the individual for whom a claim for benefits was denied, including the individual's name, date of birth, VSP Identification Number, the name of the provider of services and the claim number. You may set out the reasons you believe that the claim denial was in error and you may also provide any pertinent documents to be reviewed.

You or your authorized representative should submit all requests for appeals to:

VSP Member Appeals
P. O. Box 2350
Rancho Cordova, CA 95741
1-800-877-7195

Determinations on Appeal for Vision Claims

VSP will review the claim and give you the opportunity to review relevant documents, submit any statements, documents, or written arguments in support of the claim, and to appear personally to present materials or arguments.

VSP's determination, including specific reasons for the decision, will be provided, and communicated to you within thirty (30) calendar days after receipt of a request for appeal.

If you disagree with VSP's determination on appeal, you may request a second level appeal within sixty (60) calendar days from the date of the denial of your first appeal. The appeal should be sent to the same address as set forth above.

VSP will provide you with a determination on your second level appeal within thirty (30) calendar days (fifteen (15) calendar days in the case of authorization for low vision benefits). If the decision upholds the denial of your claim, the notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific Plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- If the denial was based on medical necessity or a determination of experimental or investigational treatment or similar exclusion or limit:
  - An explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your circumstances; or
  - A statement that such an explanation will be provided free of charge upon request.
- If an internal rule, guideline, protocol, or other similar criterion was relied on in denying your claim:
  - A description of the specific rule, guideline, protocol, or criterion relied on, or
  - A statement that a copy of such a rule, guideline, protocol, or criterion will be provided free of charge upon request.
- A statement of your right to bring a civil action under Section 502 of ERISA.

The decision of VSP is final and binding on all individuals dealing with or claiming benefits under the Plan.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

COORDINATION OF BENEFITS

Coordination with Other Plans

BJC HealthCare Medical and Dental Plan

The BJC HealthCare Medical and Dental Plan includes a coordination-of-benefits (COB) provision. This applies to people who are covered by more than one medical group plan. Under COB, one group plan is considered “primary” and the other “secondary.” The primary group plan always pays first and usually pays full regular benefits. In addition, please note that if two BJC employees are married, they cannot cover themselves or their dependents under both the employee's and the spouse's BJC coverage for medical, dental or vision coverage.

If you or any of your dependents are eligible to receive benefits from another group plan that is the primary plan, the benefits of the Plan will be reduced by the primary group plan’s payment.

The primary plan is determined in the following order:

- The Plan is always secondary to no-fault automobile coverage, personal injury protection coverage (PIP) and medical payment coverage (Med Pay).
- If a plan covers the patient (claimant) as an employee or retiree, then that plan is primary, and any plan that covers that person as a dependent is secondary.
- Any plan that does not contain a coordination-of-benefits provision is primary.
- If a plan covers the patient as an active employee, that plan is primary, and any plan that covers that person as a retired or laid-off employee is secondary. If a plan covers the patient as a dependent of an active employee, that plan is primary, and any plan that covers that person as a dependent of a retired or laid-off employee is secondary.
- If a plan covers a person because of federal or state continuation-of-coverage laws, that plan is secondary to a plan that covers the person on any other basis.
- If the above rules do not apply, the plan that has covered the individual the longest period of time usually is primary.

Special Rules for Dependent Children

There are special rules for determining the primary plan when the patient is a dependent child:

- If the patient is a dependent child whose parents are not divorced or separated, the plan of the parent whose birthday occurs earlier in the year is primary. For this purpose, the year of birth is not relevant.
- If both parents have the same birthday, the benefits of the plan which covered the parent longer are determined before those of the plan which covered the other parent for a shorter period of time.
- If the patient is a dependent child whose parents are divorced or separated, the plan of the parent who has been ordered by a court to provide health coverage for the patient is primary. If neither parent is under court order to provide health coverage, the plan of the parent who has custody of the dependent child is primary. The plan of the custodial parent’s spouse is secondary, and the plan of the other natural parent is third.

Providing Necessary Information

When claiming benefits under the BJC HealthCare Medical and Dental Plan, you may be required to furnish payment or enrollment information concerning your other group coverage. This allows the Benefits Manager to implement the provisions of the Plan.

How Benefits are Coordinated

When another group plan is primary, the benefits of the BJC HealthCare Medical and Dental Plan are reduced by the amount of the other plan’s payment.

In other words, if the primary plan’s payments are equal to or greater than those of the BJC HealthCare Medical and Dental Plan, then the Plan will pay nothing for that claim.

If your primary plan's benefits are less than what this Plan pays, then this Plan will pay the difference (between what the primary plan paid and what this Plan would have paid had it been primary), not to exceed the total amount of the claim. For example:

- If your other plan's benefits for a claim are $480, and this Plan would pay $480 for the same claim, then this Plan will pay nothing.
- If your other plan's benefits are $400, and this Plan would pay $480 for the same claim, then this Plan will pay $80.

These rules apply only when another plan is primary, and your Plan is secondary. If your Plan is primary, its benefits are determined as if no other plan is involved; however, a secondary plan may pay additional benefits.

When selecting this Plan as secondary coverage, please be aware that if the amount paid by the primary coverage is more than what the Plan would pay, the Coordination of Benefits Provision of the Plan provides that the Plan would pay nothing. Therefore, in most cases, it is likely that you will receive no additional benefits under the Plan and will be responsible for any out-of-pocket expenses (e.g., deductibles and copayments) incurred through your primary plan.

To ensure you receive the benefits to which you are entitled from both plans, it's important to submit your claims properly. For example, when you file a claim for your spouse, be sure to file under his or her plan first. After you have received payment from your spouse's plan, then you can submit for payment to your plan. When you submit a claim to the second plan, be sure to include the Explanation of Benefits (EOB) from the primary plan, as well as another copy of the bill.

Coverage for Employees and Certain Dependents Who Are Eligible for Medicare

The Plan assumes that all active employees and their spouses and children will be provided with primary coverage from the Plan, with secondary coverage provided by Medicare.

For individuals entitled to Medicare because of end-stage renal disease, the Plan will be secondary, and Medicare will be primary after thirty (30) months of coverage.

In any situation where this Plan would have been secondary to Medicare had the Plan participant enrolled, this Plan will not pay for any expenses that otherwise would have been paid under Medicare Parts A and/or B regardless of whether or not the Plan participant actually enrolled. The consequences of this provision should be taken into account when you are making your decision to enroll in Medicare.

BJC Healthcare Vision Plan

The VSP insurance policy underlying the BJC HealthCare Vision Plan also contains a COB provision. Generally, benefits are coordinated under substantially the same rules as described above for the BJC HealthCare Medical and Dental Plan. In certain instances, however, the VSP COB terms provide that if another Plan does not contain the same rules as the Vision Plan, the rule will be ignored, or in the case of the "birthday rule" for determining which parent's plan is primary for the coverage of a dependent child, the rule in the other plan will be determinative.

Right of Recovery

Whenever the BJC HealthCare Medical and Dental Plan has paid expenses that were in excess of the maximum amount necessary to satisfy a provision, the Plan has the right to recover the excess payments.

If any individual covered under the Plan (a "Covered Individual") sustains an illness, sickness, disease, condition or injury ("Illness or Injury") for which benefits are payable under the terms of the Plan, and a Third Party is or may be liable with respect to such Illness or Injury (the "Third Party"), the Plan shall have the right of recovery (the "Right of Recovery"). The Plan shall have the Right of Recovery with respect to any recovery, right of recovery, claim, cause of action or other rights that any or all Interested Parties may have against a Third Party.

The term Third Party means any entity or person, including but not limited to, an insurance company (e.g., the Covered Individual's own insurance company, in the case of uninsured or underinsured motorist coverage or no-fault automobile insurance). The term Interested Party means any person or entity who has or may have a right of recovery, claim, cause

of action or other right arising out of or related to the Illness or Injury (or any loss related thereto) sustained by the Covered Individual; such term shall include, but shall in no way be limited to, the Covered Individual's estate (or personal representative of the estate), heirs, guardian or other representative.

The Right of Recovery includes:

- The right to recover from any Interested Party all amounts the Interested Party may recover or receive from any Third Party with respect to the Illness or Injury for which benefits are payable under the terms of the Plan;
- The right to reduce the amount of covered Plan benefits payable with respect to the Illness or Injury, by any amount or amounts recovered by an Interested Party from a Third Party with respect to or as a result of the same Illness or Injury; and
- The right of subrogation to stand in the shoes of an Interested Party and assert any right of recovery, claim or cause of action that the Interested Party may have against a Third Party arising from or related to the Illness or Injury for which benefits are payable under the terms of the Plan; the Plan's right of subrogation includes the right to control absolutely the prosecution of the subrogated right of recovery, claim or cause of action, including, but not limited to, the selection of counsel.

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

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

If a Participant or Interested Party recovers any amount from a Third Party with respect to an Illness or Injury for which benefits are payable under the Plan, the Participant or Interested Party shall serve as a constructive trustee over such amounts. Such amounts shall belong to the Plan and the Plan Administrator and the failure to hold such amounts in trust for the Plan will be a breach of fiduciary duty to the Plan. No disbursement of such amount shall be made until the Plan's Right of Recovery is fully satisfied.

If the Plan has a Right of Recovery, the Plan shall not be obligated to pay any Plan benefits with respect to the Covered Individual's Illness or Injury until all of the following conditions are fulfilled to the complete satisfaction of the Plan Administrator in its sole and absolute discretion:

- If the Plan Administrator desires to assert the Plan's right of subrogation, all Interested Parties (or someone legally qualified and authorized to act for an Interested Party) must sign all documents required by the Plan Administrator to assert such right.
- If the Plan Administrator, in its sole and absolute discretion, decides not to assert the Plan's right of subrogation, all Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to the following conditions:

(i) The Interested Party shall agree to include Plan benefits in any claim or cause of action the Interested Party makes against a Third Party for the Illness or Injury (or any loss related thereto);

(ii) The Interested Party shall agree that the Plan has an absolute Right of Recovery and a first priority lien upon any recovery made by the Interested Party related to the Illness or Injury for which Plan benefits have or will be paid; and

(iii) The Interested Party shall agree not to settle a claim against a Third Party without prior written consent of the Plan Administrator.

- All Interested Parties (or someone legally qualified and authorized to act for an Interested Party) shall agree in writing to cooperate fully with the Plan in asserting and protecting its Right of Recovery, supply the Plan Administrator with any and all information necessary to assert and protect such Right of Recovery, and execute and deliver any and all instruments and papers in their original form.

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

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

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

TERMINATION OF COVERAGE

For Medical (including Pharmacy), Dental and Vision Coverage

When Employee Coverage Ends

Your coverage will end on the earliest of the following dates:

- The last day of the month in which you terminate employment or otherwise cease to be a benefit eligible employee.
- The last day of the Plan Year if you cancel coverage during annual enrollment or fail to enroll during annual enrollment (applies to medical/pharmacy coverage only).
- The last day of the month following the date you submit notice to drop due to a qualified change in status event (see the section *Changing Coverage* in this SPD), provided you do so within thirty-one (31) days of the date of the event.
- The date on which the Plan ends, or your employer no longer provides employee medical, dental, or vision benefits.
- The date on which the Plan Administrator terminates your coverage for cause. “Cause” means the covered person’s willful engagement in misconduct that is materially injurious to the Plan or your employer, dishonesty by the covered person in connection with the provision of benefits under the Plan, fraudulent or unethical conduct or an intentional misrepresentation of a material fact by the covered person relating to or affecting the provision of benefits under the Plan, the covered person being indicted or charged with any crime constituting a felony or the covered person’s failure to repay amounts due and owing to the Plan or a participating employer.

When Qualified Dependent Coverage Ends

Coverage for your qualified dependents will end on the earliest of the following dates:

- The date on which your coverage as an employee ends for any reason.
- While employed, you may voluntarily drop dependent coverage only during the annual enrollment period or when you have a qualified change in status as defined by the Plan. Coverage will end the last day of the month (or last day of the Plan Year if the change is made at annual enrollment).
- The last day of the month in which the qualified dependent ceases to be eligible. NOTE: If you do not notify the Plan within thirty-one (31) days of a change in status event that causes your dependent to lose eligibility under the Plan, the ineligible dependent’s coverage will still terminate as of the last day of the month in which he or she became ineligible. If the removal of the dependent results in a lower contribution (e.g., from family level to employee+spouse), contributions will be reduced accordingly on a going-forward basis from the date the Plan Administrator receives notification. Any prior contributions already paid from the date coverage terminated will not be refunded.
- The date the Plan Administrator terminates your qualified dependent's coverage for cause, as defined above.

If your qualified dependent engages in any conduct described previously that would result in the termination of your coverage had you engaged in such conduct, your dependent’s coverage will end as described above.

Retroactive Termination

In the case of medical coverage only (including pharmacy), the Plan Administrator may only retroactively terminate a covered person's coverage as follows:

- in the case of fraud or an intentional misrepresentation of a material fact;
- due to a failure to pay required contributions toward the cost of coverage; or
- for any purpose that is not considered a "rescission" under the Patient Protection and Affordable Care Act or any regulations or other guidance issued with respect to such Act. When required by law or regulation, the Plan Administrator will provide written notice of a rescission. The Plan may recover

from you amounts it paid for services provided to you or your covered dependents after the date coverage was terminated.

During a Leave of Absence

Your medical (including pharmacy), dental and vision coverage will be continued while you are on an approved leave of absence as long as you continue making your required contributions, according to your employer's leave of absence policy. If your contributions are more than thirty (30) days late, your coverage under the Plan will end. If your leave was approved under the Family and Medical Leave Act of 1993 and your coverage ended for nonpayment of contributions, you will be entitled to the same benefits upon your return to work as you had prior to your coverage ending, however, the coverage will be effective from the date you return to work.

If you continue your coverage and then fail to return to work at the end of your leave, you may be required to reimburse your employer for its cost of providing you coverage during your leave. You will not be required to repay the employer if the reason you do not return is due to a serious health condition which would entitle you to take a leave under the Family and Medical Leave Act or other circumstances beyond your control.

COBRA

You and your qualified dependents may be offered COBRA continuation coverage when your coverage under the Plan would otherwise end because of a life event known as a "qualifying event." COBRA continuation coverage generally consists of the coverage under the Plan that you and your family members had immediately before the qualifying event. This includes medical, dental and vision coverage as well as coverage under the Health Care Flexible Spending Account (Health Care FSA) that is in effect at the time of your qualifying event. You may elect to continue to participate in the Health Care FSA (on an after-tax basis) if the maximum benefit available to you under the Health Care FSA as of the date of the qualifying event exceeds the amount that is required for you to continue coverage for the remainder of the Plan Year on an after-tax basis. However, you may only continue your Health Care FSA through the end of the year in which your qualifying event occurs.

Each qualified beneficiary who elects COBRA continuation coverage will have the same rights under the Plan as other similarly situated participants or beneficiaries covered by the Plan who did not have a qualifying event. This includes the right to add dependents if they qualify for a HIPAA special enrollment period. If the Plan changes benefits, premiums, etc., continuation coverage changes accordingly. During annual enrollment, each qualified beneficiary will have the same options under COBRA coverage as active employees covered under the Plans with the exception of the Health Care FSA. As noted above, the Health Care FSA can only be continued through the end of the Plan Year in which your qualifying event occurs.

When COBRA Continuation Coverage Is Available

The specific qualifying events that trigger the right to elect COBRA continuation coverage are listed below. After a qualifying event, COBRA continuation coverage will be offered to each person who is a "qualified beneficiary." You, your spouse, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event.

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

- Your hours of employment are reduced to a benefits-ineligible status, or
- Your employment ends for any reason other than your gross misconduct.

If you are the **spouse** of an employee, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events occurs:

- Your employee-spouse dies;
- Your employee-spouse's hours of employment are reduced to a benefits-ineligible status;
- Your employee-spouse's employment ends for any reason other than his or her gross misconduct;

- Your employee-spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced from your employee-spouse.

An employee's **dependent children** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events occurs:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced to a benefits-ineligible status;
- The parent-employee's employment ends for any reason other than his or her gross misconduct;
- The parent-employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parent-employee becomes divorced; or
- The child stops being eligible for coverage under the Plan as a "dependent child."

SPECIAL RULE FOR RETIREES: Sometimes, the filing of a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event. If such a proceeding is filed with respect to your BJC employer and as a result of that filing, a retired employee loses coverage under the Plan, or if there is a substantial elimination of coverage within one year before or after the date the bankruptcy was filed, the bankruptcy will be a qualifying event and the retired employee will be a qualified beneficiary with respect to the bankruptcy. The retired employee's spouse, surviving spouse and dependent children will also become qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan. In that event, the retiree will be entitled to coverage for life and the spouse and covered dependents of the retiree will be entitled to coverage for the life of the retiree. If the retiree dies during the continuation period, then the other qualified beneficiaries shall be entitled to continue coverage for up to thirty-six (36) months from the date of the retiree's death. If the retiree is not living at the time of the qualifying event but the retiree's spouse has coverage, the surviving spouse is entitled to continued coverage for life.

Qualified beneficiaries will be offered COBRA continuation coverage only after the COBRA Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), your employer will notify the COBRA Administrator of the qualifying event.

You Must Give Notice of Some Qualifying Events

For the other qualifying events (divorce of the employee and spouse, or a dependent child's losing eligibility for coverage as a dependent child), you must notify the COBRA Administrator in writing within sixty (60) days after the qualifying event occurs. This notice should be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

The notice must include the employee's name, the name of the spouse, and/or dependent child, the nature of the qualifying event (e.g., divorce or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or the date the dependent child lost dependent status (e.g., reached the Plan's limiting age)).

If notice is not provided during this 60-day notice period, the spouse or dependent child who loses coverage will not be offered the opportunity to elect COBRA continuation coverage.

Duration of COBRA Coverage

COBRA continuation coverage is a temporary continuation of coverage. The duration of the coverage depends on the nature of the qualifying event that causes the loss of coverage:

- When the loss of coverage is on account of the death of the employee, the employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), divorce, or a dependent child's losing eligibility as a dependent child, COBRA continuation coverage for the employee's spouse and/or dependent child may last for up to a total of thirty-six (36) months.

- When the loss of coverage is on account of the employee's termination of employment or reduction of hours of employment, COBRA continuation coverage for the employee and his or her spouse and dependent children generally may last for up to a total of eighteen (18) months.

A special rule applies if the employee becomes entitled to Medicare benefits less than eighteen (18) months before the end of employment or reduction in hours. In that situation, the employee is still entitled to up to eighteen (18) months of COBRA continuation coverage under the general rule described above. However, COBRA continuation coverage for qualified beneficiaries other than the employee may last up to thirty-six (36) months after the date of the employee's Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight (8) months before the date on which his employment terminates, COBRA continuation coverage for his or her spouse and children can last up to thirty-six (36) months after the date of Medicare entitlement. Thus, their COBRA continuation coverage may continue for up to twenty-eight (28) months after the date of the qualifying event (36 months minus 8 months). If the employee becomes entitled to Medicare more than eighteen (18) months prior to the end of employment or reduction of hours, the general rules apply.

Extension of the 18-Month Period of Continuation Coverage

There are two ways in which the 18-month period of COBRA continuation coverage can be extended.

Disability extension. If the Social Security Administration (SSA) determines that you or a family member covered under the Plan is disabled and the COBRA Administrator receives timely notice of that determination, you and your other family members may be entitled to receive up to an additional eleven (11) months of COBRA continuation coverage, for a maximum of twenty-nine (29) months of COBRA coverage. The disability must have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the initial 18-month period of COBRA continuation coverage. In order for the extension to be available, you must notify the COBRA Administrator in writing of the disability determination during the first eighteen (18) months of COBRA continuation coverage and no more than sixty (60) days after the latest of: (i) the date of the SSA determination, (ii) the date of the qualifying event, or (iii) the date coverage would end on account of the qualifying event.

The notice must be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. It must include the employee's name, the name of the disabled individual as well as copy of the Social Security Administration disability determination.

A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

If notice is not provided within the above timeframes, the 18-month maximum coverage period will not be extended.

The disability extension is available only for as long as the family member remains disabled. The COBRA Administrator must be notified if the Social Security Administration makes a final determination that the individual is no longer disabled. Continuation coverage will end on the first day of the month that begins more than thirty (30) days after the date of the determination.

Second qualifying event. If your family experiences a second qualifying event while receiving 18 months of COBRA continuation coverage, the spouse and dependent children in your family may be entitled to receive up to 18 additional months of COBRA continuation coverage, for a maximum of thirty-six (36) months of COBRA coverage. This extension may be available if the employee or former employee dies, is divorced, or if a child no longer qualifies as a dependent child under the terms of the Plan, but only if the event would have caused the spouse or dependent child to lose coverage under the Plan had the first qualifying event not occurred. Coverage will be extended only if you or your family members provide notice of the second qualifying event to the COBRA Administrator no more than sixty (60) days after the event occurs.

This notice should be sent to the COBRA Administrator at the address specified in the section *How to Contact the COBRA Administrator*. The notice must include the employee's name, the name of the spouse and/or dependent child, the nature of the second qualifying event (e.g., divorce or a child's loss of dependent status) and the date the qualifying event occurred (date of divorce or the date the dependent child lost dependent status (e.g., reached the Plan's limiting age)).

A notice mailed to the COBRA Administrator will be considered provided on the date of mailing.

If notice is not provided during this 60-day notice period, COBRA continuation coverage will not be extended beyond the initial 18-month period.

Electing COBRA Continuation Coverage

Once the COBRA Administrator receives timely notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each qualified beneficiary. You and/or your spouse and your dependent children will have sixty (60) days in which to elect COBRA continuation coverage. This 60-day election period begins on the later of:

- The date coverage would end because of the qualifying event; or
- The date the COBRA Administrator provides notice of the right to elect COBRA.

A COBRA election mailed to the COBRA Administrator will be considered made on the date of mailing.

If COBRA continuation coverage is not elected during the 60-day election period, the right to elect continuation coverage will be lost.

You and/or your spouse and your dependent children may elect COBRA continuation coverage for all qualifying family members. However, each qualified beneficiary has an independent right to elect continuation coverage. Thus, both you and your spouse may elect continuation coverage, or only one of you may do so. You may also elect to continue coverage on behalf of your dependent children only.

Paying for COBRA Continuation Coverage

You must pay the full cost of COBRA continuation coverage. Your first payment must be made within forty-five (45) days of the date that the COBRA election was made. If payment is not received within this 45-day period, the Plan Administrator will terminate coverage retroactively to the beginning of the maximum coverage period.

After the initial premium payment is made, all other premiums are due on the first day of the month to which such premium will apply, subject to a 30-day grace period. A premium payment that is mailed will be considered made on the date of mailing. If the full amount of the premium is not paid by the due date or within the 30-day grace period, COBRA continuation coverage will be canceled retroactively to the first day of the month with no possibility of reinstatement.

The amount of the premium for COBRA continuation coverage will not exceed 102% of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving COBRA continuation coverage. In the case of an extension of COBRA continuation coverage due to a disability, the amount of the premium will increase to 150% of the cost of coverage.

Survivor Benefit

If you are the spouse or dependent child of an employee who has died, and you elect COBRA continuation coverage, there will be no charge to you for the first two (2) months of coverage. Note that you must complete the necessary COBRA paperwork within the required timeframe in order to receive COBRA continuation coverage; it will not be provided automatically. After the first two (2) months, you will be required to pay the entire cost of the COBRA continuation coverage in order to continue to be covered for the remainder of the coverage period.

You should also note that if you elect to drop COBRA continuation coverage before the end of the coverage period (e.g., after the first two months of coverage for which there is no charge), your voluntary decision to drop coverage is not an event that would provide you with a special enrollment opportunity to elect coverage offered by an exchange created under the Affordable Care Act. You would be able to enroll only during the annual enrollment period or if another event caused you to have a special enrollment opportunity.

When COBRA Continuation Coverage Ends

An individual's COBRA continuation coverage will end before the expiration of the maximum coverage period if any of the following events occurs:

- The premium for coverage is not paid in a timely manner;
- After electing COBRA continuation coverage, the qualified beneficiary becomes covered under another group health plan that does not contain an exclusion or limitation with respect to any pre-existing condition that the individual may have;
- After electing COBRA continuation coverage, the qualified beneficiary enrolls for Medicare;
- If coverage is extended on account of disability, the Social Security Administration makes a determination that the individual is no longer disabled; or
- BJC no longer provides group health coverage to any of its employees.

Continuation coverage also may be terminated for any reason that the Plan Administrator would terminate coverage of a participant or beneficiary not receiving continuation coverage, such as a termination for cause, as defined in the *Termination of Coverage For Medical (including Pharmacy), Dental* and *Vision Coverage* section of this SPD; provided, however, the Plan Administrator may only retroactively terminate a qualified beneficiary's COBRA coverage for any purpose that is not considered a "rescission" under the Patient Protection and Affordable Care Act or any regulations or other guidance issued with respect to such Act.

If You Have Questions

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

Keep BJC Informed of Address Changes

In order to protect your family's rights, you should keep BJC and the COBRA Administrator informed of any changes in the addresses of family members. If you have a qualifying event, you should also keep a copy of any notices you send to the COBRA Administrator for your records.

How to Contact the COBRA Administrator

All required notices should be mailed to the COBRA Administrator at the following address:

WEX
PO Box 2079
Omaha, NE 68103-2079

Fax at: 888-408-7224

You can also call the COBRA Administrator at 866-451-3399, option 1 (self-help) or option 2 (to speak with a representative) if you have any other questions about COBRA continuation coverage.

USERRA

If You Are on a Military Leave

If you (the employee) take a leave of absence in order to serve in the uniformed services, the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) gives you the right to continue group health care coverage for yourself (and your covered dependents, if any) for up to twenty-four (24) months from the date your leave of absence begins.

Your USERRA continuation coverage will terminate earlier if one of the following events occurs:

- You fail to pay any premium within the required time;
- You lose your USERRA rights due to a dishonorable discharge or other conduct specified in USERRA; or
- You fail to report to work or to apply for reemployment following the completion of your service in the uniformed services within the time required by USERRA as described in the chart below.

USERRA and COBRA. USERRA and COBRA coverage run concurrently, which means that they begin at the same time. However, COBRA coverage can continue for up to eighteen (18) months (and for longer periods under certain circumstances) while as noted above, USERRA coverage can continue for up to twenty-four (24) months. In addition, COBRA coverage is subject to early termination for additional reasons that do not apply to USERRA coverage. For more information about COBRA continuation coverage see the *COBRA* section of this SPD.

Payment of Premiums. If you elect to continue health coverage under USERRA, you will be required to pay 102% of the full premium for the coverage elected (the same rate as COBRA). However, if your uniformed service period is less than thirty-one (31) days, you are not required to pay more than the amount that you pay for such coverage as an active employee.

Whom to Contact. If you leave employment to enter military service, you should contact your human resources (HR) Representative to determine whether you also have health care coverage continuation rights under USERRA.

Military Leave	
If Your Period of Uniformed Service Is:	**You Must Report-to-work/Submit an Application for Reemployment Not Later than:**
Less than 31 days (or if you are absent for purposes of an examination to determine your fitness to perform uniformed services)	The beginning of the first regularly scheduled work period on the day following the completion of your service after allowing for safe travel home and an 8-hour rest period, or if that is unreasonable or impossible through no fault of your own, as soon as possible*
More than 30 days but less than 181 days	14 days after completion of your military service or if that is unreasonable or impossible through no fault of your own, as soon as possible*
More than 180 days	90 days after completion of your service*
*If you are hospitalized for or are convalescing from an injury or illness incurred or aggravated as a result of your service, the applicable time periods begin when you have recovered from your injuries or illness rather than upon completion of your service. The maximum period for recovery generally is two years from completion of service.	

LEGAL NOTICES

HIPAA

HIPAA Privacy Rights

You may obtain a copy of the "Notice of Privacy Practices for the BJC Plans." This document describes your privacy rights under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and also describes how the BJC covered group health plans will use and disclose your personal health information. The notice is available in your HR department, on BJCtotalrewards.org, or upon request via mail to your local HR representative.

HIPAA Special Enrollment Rights

There are three circumstances in which you will qualify for HIPAA special enrollment rights. These rights only apply to medical (including pharmacy) benefits.

1. ***You acquire a new dependent.*** If you acquire a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may enroll yourself and your new dependent (and your spouse, in the case of birth or adoption of a child) in any medical benefit option available to you. If you are already enrolled in BJC medical coverage when you acquire a new dependent, you may enroll your dependent in your current medical benefit option or you may change your election and enroll yourself and your dependent in a different medical benefit option available to you.

   To exercise your special enrollment rights, you must enroll yourself and/or your dependents no later than thirty-one (31) days (in the case of marriage) or sixty (60) days (in the case of birth, adoption, or placement for adoption) after the date you acquire the new dependent. All BJC medical coverage enrollment requirements will apply. If you acquire a dependent child through birth, adoption, or placement for adoption, the new election will be effective on the date of birth, adoption, or placement for adoption as long as your enrollment is submitted no later than sixty (60) days after such date. If you acquire a dependent through marriage, the new election will be effective on the first day of the month on or after the date of your marriage as long as your enrollment is submitted no later than thirty-one (31) days after the date you acquire the dependent.

   If you do not enroll a new dependent within thirty-one (31) days or sixty (60) days, as applicable, you will not be permitted to enroll the dependent until the next annual enrollment period.

2. ***You or a dependent loses other coverage***. If you opted out or waived enrollment for yourself or for an eligible dependent because other health coverage (including COBRA coverage) was in effect, you may enroll yourself and your dependents in BJC medical coverage if you or your dependents lose eligibility for that other coverage or if employer contributions for that coverage are terminated.

   For this purpose, "loss of eligibility" includes, but is not limited to:

   A loss of coverage that results from termination of employment, reduction in hours of employment, divorce, death, or cessation of dependent status (e.g., reaching the maximum age to be eligible as a dependent under a plan);

   A situation in which an individual incurs a claim that would meet or exceed a lifetime limit on all benefits under the other plan; or

   A situation in which a plan no longer offers any benefits to the class of individuals of which that individual is a part.

   Loss of eligibility for other coverage does not include a loss due to the failure to pay premiums on a timely basis or termination of coverage for cause, such as fraud.

   If you were not enrolled in BJC medical coverage, you may enroll yourself and your eligible dependents in any medical benefit option available to you. If you already are enrolled in BJC medical coverage and one of your dependents loses other coverage (or employer contributions for the other coverage terminate), you may enroll your dependent in

your current medical benefit option or you may change your election and enroll yourself and your dependent in a different medical benefit option available to you.

To exercise your special enrollment rights, you must enroll yourself and/or your dependents no later than thirty-one (31) days after the date the other coverage ends (or employer contributions terminate). All BJC medical coverage enrollment requirements will apply. The new election will be effective on the first day of the month on or after the loss of other coverage.

3. ***Loss of Medicaid or CHIP Eligibility / Eligibility for State Assistance.*** If you or an eligible dependent are enrolled for coverage under Medicaid or a state children's health insurance program (CHIP), and that coverage is terminated as a result of loss of eligibility, you may enroll yourself and your eligible dependent in any BJC medical benefit option available to you. You may also enroll yourself and your eligible dependent in any BJC medical benefit option available to you if you or your dependent becomes eligible for a Medicaid or CHIP premium-assistance subsidy for BJC medical coverage under the Plan.

   If you were not enrolled in BJC medical coverage, you may enroll yourself and your eligible dependents in any medical benefit option available to you. If you are already enrolled in BJC medical coverage, you may enroll your dependent in your current option, or you may change your election and enroll yourself and your dependent in a different option available to you.

   To exercise your special enrollment rights, you must enroll yourself and/or your dependents no later than sixty (60) days after the date Medicaid or CHIP coverage terminates or the date you or your dependent are determined to be eligible for premium assistance for BJC medical coverage. All BJC medical coverage enrollment requirements will apply. The new election will be effective on the first day of the month on or after the loss of Medicaid or CHIP, or eligibility for a premium-assistance subsidy.

FLEXIBLE SPENDING ACCOUNTS

Through the benefits program, you have the opportunity to save money by taking advantage of two (2) Flexible Spending Accounts (FSAs):

- Health Care Flexible Spending Account (Health Care FSA)
- Dependent Care Flexible Spending Account (Dependent Care FSA)

With these accounts, you can set aside money from your paycheck before taxes are withheld to pay for eligible health and dependent care expenses during the year. That money is credited to your accounts to be paid back to you—tax free—when you have an eligible expense. You must use the money set aside in your flexible spending accounts for eligible expenses. For purposes of the FSAs, a "Plan Year" means a 12-month calendar year, beginning on January 1st and ending on December 31st of the same calendar year.

If you participated in the Health Care FSA and/or Dependent Care FSA for the 2021 Plan Year, you may carry over unused amounts in these accounts equal to or greater than $50 for use during the 2022 Plan Year.

If you participate in the Health Care FSA for the 2022 Plan Year, you may carry over unused amounts equal to or greater than $50 and up to $570 for use during the next Plan Year. All other unused amounts from the 2022 Plan Year will be forfeited.

Eligibility

You are eligible to participate in the FSAs if you are classified as a regular full-time employee who works at least thirty-five (35) hours per week (seventy (70) hours per pay period), or as a regular part-time employee who works at least twenty-four (24) hours per week (or forty-eight (48) hours per pay period), regardless of retroactive reclassification.

Temporary, PRN and per diem employees are not eligible to participate in the FSAs under the BJC HealthCare Flexible Benefits Plan.

For purposes of initial eligibility, the term "works" within this SPD means the budgeted hours in BJC's payroll system, not the hours actually worked. In order to maintain and continue eligibility to participate in the FSAs after your initial eligibility date, you must continue to actually work a minimum of: thirty-five (35) hours per week (seventy (70) hours per pay period) if you are a regular full-time employee or twenty-four (24) hours per week (forty-eight (48) hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare's payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee's audit, to update an employee's eligibility status based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include PTO, STD, low census, and unpaid approved leave hours.

Enrollment Process

If you wish to participate in either of the FSAs, you must complete your enrollment no later than within thirty-one (31) days after your hire date. For this purpose, "hire date" means the date you are first classified as an employee in the payroll system. After your initial choice, you will not have another opportunity to enroll, cancel or change your deposit amounts until the next annual enrollment period, or until you experience a change in status event. If you experience a qualified change in status event as indicated in the *Changing Coverage* section of this SPD, you must complete your enrollment no later than thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption).

Enrollment to actively contribute to these accounts is not automatic from year to year. To actively contribute for a Plan Year, you must make an election to contribute during the annual enrollment period.

When Coverage Begins and Ends

When Coverage Begins for Employees

Your coverage will be effective on the first day of the month following your hire date or the first day of the month on or after your change in status event date, provided you have timely enrolled. As noted previously, your online enrollment must be completed no later than: (a) thirty-one (31) days after your hire date, or (b) thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption).

You will not be permitted to change your coverage until the next Plan Year during the annual enrollment period unless you experience a qualified change in status event.

Regardless of when you enroll in an FSA, you can only be reimbursed for expenses incurred during the time you participated in that account. For example, if you begin participating in a Health Care FSA on June 1, and you remain employed until December 31, you may request reimbursement of eligible health care expenses incurred June 1–December 31.

When Coverage Ends

If your employment ends or you are no longer an eligible employee, your participation in the FSAs will continue through the end of the month in which the event occurred.

You will not be able to claim health care expenses under the Health Care FSA incurred after that date unless you continue your account through COBRA. For more information about continuation of your Health Care FSA, please refer to the *COBRA* section of this SPD.

If you have a balance remaining in your Dependent Care FSA, you may use it for eligible dependent care expenses incurred for ninety (90) days from the date your Dependent Care FSA ends or within the same Plan Year, whichever occurs earliest.

If you go on a leave of absence:

- You may continue to make contributions to your Health Care and/or Dependent Care FSAs while you are on an approved leave.
- If you choose to stop contributions to your Health Care and/or Dependent Care FSAs during your leave, you will have the following options when you return to work:
  - You may choose not to participate for the remainder of the Plan Year.
  - You may reinstate your salary reduction amount of your prior elections, in which case the amount of the salary reduction will remain the same, but the total amount of your election will be prorated.
  - You may reinstate the dollar amount of your prior elections in which case the amount of your salary reduction will increase, and the total amount of your election will remain unchanged.
  - You may make new elections consistent with a change in status.
- If you cancelled your Health Care FSA election while you were on leave, any expenses incurred during the period of the lapse in coverage will not be eligible for reimbursement.
- Dependent care expenses incurred during a leave of absence are not eligible for reimbursement under your Dependent Care FSA.

Health Care Flexible Spending Account (FSA)

The Health Care FSA enables you to pay for expenses allowed under Sections 105 and 213(d) of the Internal Revenue Code which are not covered by BJC's medical, prescription drug, dental, and/or vision Plans and save taxes at the same time. The Health Care FSA allows you to be reimbursed for expenses incurred by you and your dependents.

You may be reimbursed for "over the counter" drugs. You may not, however, be reimbursed for the cost of other health care coverage maintained outside of the Plan, or for long-term care expenses. See the section *Health Care FSA Eligible*

Expenses below for some covered expenses, or for a more detailed list of covered expenses, go to WEX's website under the Insights/Benefits Toolkit page: wexinc.com.

If you choose to participate in the Health Care FSA, you will designate a dollar amount - up to the maximum amount per Plan Year as communicated in the enrollment process (e.g., $2,750 for 2022) - that will be deducted from each paycheck during the year in equal installments on a before-tax basis and "credited" to your account. The minimum amount that you may contribute to the Health Care FSA each Plan Year is $130, or $5.00 each pay period. For the 2021 Plan Year, you will be eligible to carry over amounts left in your Health Care FSA equal to or in excess of $50. This means that amounts you did not use during the 2021 Plan Year can be carried over to the next Plan Year and used for expenses incurred in the 2022 Plan Year. For the 2022 Plan Year, you will be eligible to carry over amounts left in your Health Care FSA of at least $50 and up to $570.

When you have an eligible health care expense, you are reimbursed for it from your account with before-tax dollars. You can use the Health Care FSA to pay eligible health care expenses for yourself, your spouse and anyone whose medical expenses may be reimbursed by the Plan on a tax-free basis as permitted under the Internal Revenue Code. This includes, for example:

- Your qualifying children (for example, your son, daughter, or stepchild) until the end of the calendar year in which the child reaches age 27.
- Your qualifying relatives — family members who are not your "qualifying children" who live with you as a member of your household if:
  - You provide over one-half of their support; and
  - They are not another individual's "qualifying child."

You may be reimbursed for these expenses only if they are incurred (have a date of service) during the Plan Year of your participation in the Health Care FSA.

Health Care FSA Eligible and Ineligible Expenses

The Plan follows IRS rules to determine what is considered a reimbursable expense under the Health Care FSA. For a detailed listing of expenses that are eligible and ineligible for reimbursement under the Health Care FSA, go to WEX's 'Eligible Expense List' at: https://www.wexinc.com/insights/benefits-toolkit/eligible-expenses/.

Examples of Health Care FSA Eligible Expenses

The following are some examples of expenses eligible for reimbursement under the Health Care FSA:

- Acupuncture
- Chiropractors' fees
- Contact lenses, including solutions used for the care of lenses (excluding replacement insurance)
- Crutches
- Deductibles, coinsurance, and copayments (the portion of expenses that you pay) under the medical (including pharmacy) and dental (including orthodontic) and vision Plans
- Exercise programs prescribed by a physician to treat a specific medical condition
- Fertility treatment
- Hearing aids
- Inpatient treatment for alcoholism or drug addiction
- Lamaze classes
- Laser eye surgery
- Massage therapy recommended by a physician to treat a specific medical condition
- Menstrual products (e.g., tampons, pads, menstrual sponges)
- Over-the-counter medications used to treat a medical condition (e.g., antacids, allergy medicines, pain relievers, cold medicines, and ointments)
- Transportation expenses to receive medical care

- Prostheses
- Weight loss programs prescribed by a physician to treat a specific medical condition
- Wheelchairs

This is not a complete listing of eligible Health Care FSA expenses. Please go to WEX's 'Eligible Expense List' at: wexbenefitsyou.com/bjc/ for a more detailed listing.

Examples of Health Care FSA Ineligible Expenses

The following are some examples of expenses not eligible for reimbursement under the Health Care FSA:

- Concierge medical fees (i.e., fees paid to obtain future access to medical services)
- Contributions to other medical plans or care that is paid for by a medical plan
- Cosmetic surgery and other similar procedures
- Cost of special foods taken as a substitute for regular diet, where the special diet is not medically necessary, and you cannot justify the cost in excess of cost of a normal diet
- Cost of toiletries, cosmetics, and similar items (e.g., soap and toothbrushes)
- Expenses that are eligible for reimbursement by any other plan or insurance
- Insurance premiums
- Payments for domestic help, companion, baby-sitter, etc., who primarily renders services of a non-medical nature (may be allowed under the Dependent Care Flexible Spending Account)
- Supplements (e.g., dietary, nutritional, herbal) without a physician's prescription
- Tattoos and ear or body piercing or branding

This is not a complete listing of ineligible Health Care FSA expenses. Please go to WEX's 'Eligible Expense List' at: wexbenefitsyou.com/bjc/ for a more detailed listing.

Taxation

Expenses for which you have been reimbursed by your Health Care FSA cannot be claimed as itemized deductions on your federal income tax return. However, keep in mind that, under IRS rules, your medical and dental expenses may be deducted from your federal income tax return only if they total more than 10% of your adjusted gross income. Since few people's health care expenses reach that high of a percentage, most find the Health Care FSA works to their advantage.

Dependent Care Flexible Spending Account (FSA)

The Dependent Care FSA enables you to pay for out-of-pocket, work-related dependent day-care cost with pre-tax dollars. If you are married, you can use the account if you and your spouse both work or, in some situations, if your spouse goes to school full-time. Single employees can also use the account.

The Dependent Care FSA provides reimbursement for custodial care of a dependent child or adult. The Dependent Care FSA does not provide reimbursement for health care expenses. Health care expenses are reimbursable under the Health Care FSA, as described in the preceding section.

An eligible dependent is someone for whom you can claim expenses on Federal Income Tax Form 2441 "Credit for Child and Dependent Care Expenses." Generally, eligible dependent children must be under age 13. Other dependents must be physically or mentally unable to care for themselves. Dependent Care arrangements which qualify include:

- A Dependent (Day) Care Center, provided that if care is provided by the facility for more than six individuals, the facility complies with applicable state and local laws;
- An Educational Institution for pre-school children. For older children, only expenses for non-school care are eligible; and
- An "Individual" who provides care inside or outside your home: The "Individual" may not be a child of yours under age 19 or anyone you claim as a dependent for Federal tax purposes.

You should make sure that the dependent care expenses you are currently paying for qualify under our Plan. Please note that you may only be reimbursed for eligible dependent (day) care expenses up to your current balance in your Dependent Care FSA at the time you submit the claim.

You may use the FSA debit card to pay for dependent care expenses. See the *FSA Debit Card* section below for further details.

The law places limits on the amount of money that can be paid to you in a calendar year from your Dependent Care FSA. The minimum amount you may contribute to the Dependent Care FSA is $130, or $5.00 per pay period. Generally, your reimbursements may not exceed the lesser of: (a) $5,000 (if you are married filing a joint return or you are head of a household) or $2,500 (if you are married filing separate returns); (b) your taxable compensation; (c) your spouse's actual or deemed earned income (a spouse who is a full-time student or incapable of caring for himself/herself has a monthly earned income of $250 for one dependent or $500 for two or more dependents). If you contributed in the same year to a similar dependent care account (e.g., with a different employer before your hire), or if your spouse also has a dependent care account, the annual maximum amount you can contribute to a Dependent Care FSA is reduced by contributions to the other account. It is your responsibility to ensure that you do not exceed the annual maximum between the accounts. Once you designate an annual contribution amount, it will be deducted from each paycheck during the year in equal installments on a pre-tax basis and “credited” to your account.

Also, in order to have the reimbursements made to you from this account be excludable from your income, you must provide a statement from the service provider including the name, address, and in most cases, the taxpayer identification number of the service provider on your tax form for the year, as well as the amount of such expense as proof that the expense has been incurred. In addition, Federal tax laws permit a tax credit for certain dependent care expenses you may be paying for even if you are not a Participant in this Plan. You may save more money if you take advantage of this tax credit rather than using the Dependent Care FSA under our Plan. Ask your tax adviser which is better for you.

You will be eligible to carry over amounts left in your Dependent Care FSA from the 2021 Plan Year, equal to or in excess of $50. This means that amounts you do not use during the 2021 Plan Year can be carried over to the next Plan Year and used for expenses incurred in the 2022 Plan Year. There is no carryover option for amounts remaining in your Dependent Care FSA at the end of the 2022 Plan Year.

Dependent Care FSA Eligible Expenses

The following are some examples of expense eligible for reimbursement under the Dependent Care FSA:

- Expenses for after-school programs;
- Expenses for a summer day camp or similar program to care for your child, even if the camp specializes in a particular activity, such as soccer or computers;
- Amounts paid to a dependent care center, baby-sitter, or nurse;
- Amounts paid to a maid or cook if part of the services are provided to a person who qualifies for dependent care;
- The full amount paid to a nursery school, even when the school provides lunch (unless the cost of food can be separated from the cost of the care) and educational services;
- Amounts paid for services performed outside the home for the care of your dependent or spouse, including the cost of transporting the individual to or from the place where care is provided when transportation is furnished by a dependent care provider;
- Application fees, agency fees and deposits that you have to pay in order to obtain related dependent care services, but only if the related care is subsequently provided.

Dependent Care FSA Ineligible Expenses

The following are some examples of expenses not eligible for reimbursement under the Dependent Care FSA:

- Baby-sitting expenses when for non-work activities;
- Care in a convalescent nursing home;

- Custodial care for a dependent who resides outside your home;
- The cost of food, clothing, and education;
- Overnight camp;
- Services provided by one dependent to care for another;
- Expenses for which a dependent day care tax credit is taken or that are reimbursed under a Health Care FSA;
- Transportation between your home and the place where dependent day care services are provided if transportation is provided by you or your spouse;
- Tuition for schooling for kindergarten or higher;
- Dependent care that allows you or your spouse to do volunteer work; and
- Care provided by your spouse, by anyone considered your dependent for federal income tax purposes, by your child who is under age 19 (even if not claimed as your dependent) or, in the case of your child who is under age 13, care provided by the parent of that child.

Taxation

This section provides some taxation information regarding the Dependent Care FSA. However, you should consult a tax adviser to determine your best strategy. You may also refer to the IRS Publication 503 (Child and Dependent Care Expenses).

Choosing the Best Tax Advantage for Dependent Care

If you are a working parent, you should compare the tax advantage of the Dependent Care FSA and federal child care tax credit. Current tax laws generally make it impractical to use a combination of the two, since the maximum allowable expense under the tax credit must be reduced dollar for dollar by the amount you are reimbursed through the Dependent Care FSA.

Understanding the Federal Dependent Care Tax Credit

The dependent care tax credit is a reduction in your federal income tax for dependent care expenses incurred so you (or you and your spouse if you are married) can work. The tax credit generally is not available to a married couple filing separately. The amount of dependent care credit varies with your income level and the number of dependents you have, as you can see in the following chart.

ADJUSTED GROSS INCOME (AGI) or, if married and filing jointly, combined AGI of you and spouse	PERCENTAGE OF DEPENDENT CARE EXPENSES ALLOWED AS A TAX CREDIT
$15,000 or less	35%
$15,001-$17,000	34%
$17,001-$19,000	33%
$19,001-$21,000	32%
$21,001-$23,000	31%
$23,001-$25,000	30%
$25,001-$27,000	29%
$27,001-$29,000	28%
$29,001-$31,000	27%
$31,001-$33,000	26%
$33,001-$35,000	25%
$35,001-$37,000	24%
$37,001-$39,000	23%
$39,001-$41,000	22%
$41,001-$43,000	21%
$43,001 or more	20%

The chart above shows that the tax credit equals a percentage of your eligible dependent care costs. This tax credit can vary depending upon the current tax laws. This percentage is 35% if the combined income of you and your spouse is $15,000 or less, and gradually goes down to 20% if your combined income is more than $43,000. So, the lower your income, the greater the percentage of dependent care costs you can deduct from your income using the federal tax credit.

The maximum eligible dependent care costs you may use in calculating your federal tax credit are $3,000 per year for one dependent, or $6,000 for two or more qualifying dependents.

In general, if your adjusted gross income is more than $40,000, you will pay less federal income and Social Security (FICA) taxes by using the Dependent Care FSA instead of taking the dependent care credit on your federal taxes. You should work with a tax adviser to compare the advantages of the Dependent Care FSA and the federal dependent care tax credit program to determine which one saves you the most money.

Note that the American Rescue Plan Act of 2021 modified the Child and Dependent Care Tax Credit for 2021 only. If you have questions about those changes, please contact the BJC Benefits Department at Mailstop 92-92-248, 8300 Eager Road, Suite 300C, St. Louis, MO 63144-1412 or at 314-362-2184 for a copy of the SPD for the 2021 Plan Year.

Special Health Care FSA and Dependent Care FSA Rules

While the Flexible Spending Accounts (FSAs) are a good way for you to reduce the amount of tax you have to pay, you should be aware of several rules for these plans:

- Except for the designated Health Care FSA and Dependent Care FSA (for Plan Years 2020 and 2021) carryover amounts described below, the IRS normally requires you to forfeit any leftover money in an FSA that you do not use for eligible expenses incurred during the calendar year. This means that you should put aside money only for those expenses that you feel certain you will incur during the calendar year. Expenses are "incurred" when the service is rendered, not when you pay for it. Due to the COVID-19 pandemic, the IRS allowed an increase in the carryover amount for Health Care FSA and allowed a carry over for Dependent Care FSA for Plan Years 2020 and 2021 only.
- For Plan Year 2021, unused amounts in your Health Care FSA at end of the year equal to or in excess of $50 are carried over to the 2022 Plan Year and may be used to pay for eligible expenses incurred during the next Plan Year. Amounts that you carry over do **not** affect the maximum amount you can elect to have deducted from your pay and put into your account. In other words, if you carry over $800 from 2021 to 2022, you can still elect to deduct $2,750 from your 2022 paychecks for your account. Eligible expenses incurred in a Plan Year will be reimbursed first from amounts credited for that year and then from any carryover amounts.
- For Plan Year 2022, unused amounts in your Health Care FSA at end of the year of at least $50 and up to $570 are eligible to be carried over to the 2023 Plan Year. These carried over amounts may be used to pay for eligible expenses incurred during the 2023 Plan Year. Amounts that you carry over do **not** affect the maximum amount you can elect to have deducted from your pay and put into your account. In other words, if you carry over $570 from 2022 to 2023, you can still elect to deduct $2,750 (the maximum for 2022) from your 2023 paycheck for your account. Eligible expenses incurred in a Plan Year will be reimbursed first from amounts credited for that year and then from any carryover amounts.
- For Plan Year 2021, unused amounts in your Dependent Care FSA at end of the year equal to or in excess of $50 are carried over to the 2022 Plan Year and may be used to pay for eligible expenses incurred during the next Plan Year. Amounts that you carry over do **not** affect the maximum amount you can elect to have deducted from your pay and put into your account. In other words, if you carry over $1,500 from 2021 to 2022, you can still elect to deduct $5,000 from your 2022 paychecks for your account. Eligible expenses incurred in a Plan Year will be reimbursed first from amounts credited for that year and then from any carryover amounts. Note, amounts you deduct during the 2022 Plan Year for your Dependent Care FSA will **not** be eligible for carryover.

Please Note: Unused amounts eligible for carryover to the next Plan Year will not be reflected in your account until early April.

- The Health Care FSA and Dependent Care FSA are completely separate accounts. Account balances may not be transferred from one to the other.

- Expenses incurred before you are a participant in the Plan, or after your participation ends (for Health Care FSA), are not eligible for reimbursement. You will still be able to request reimbursement for qualifying dependent care expenses incurred within ninety (90) days from the date your Dependent Care FSA ends or within the same Plan Year, whichever occurs earliest, from the balance remaining in your dependent care account at the time of termination of employment. In addition, expenses from a given Plan Year must be paid with money credited to your FSA for that same Plan Year. Subject to the permitted Health Care FSA carryovers described above, new employees who elect Health Care FSA and/or Dependent Care FSA mid-year may only be reimbursed for eligible expenses incurred after the Health Care FSA and/or Dependent Care FSA is elected and before the end of that calendar year.
- Enrollment to actively contribute to these accounts is not automatic from year to year. Any amounts that are available to be carried over for your Health Care FSA account, and Dependent Care FSA account for Plan Years 2020 and 2021, will be carried over regardless if you elect to make additional contributions in the following Plan Year. To enroll and have an active contribution each Plan Year, you must make an election during each annual enrollment period. In general, an election you make at annual enrollment is binding throughout the Plan Year.
- You cannot alter the amount you contribute to your Health Care FSA and/or Dependent Care FSA during the Plan Year unless you have a "change in status event" that affects your benefit needs or your eligibility for benefits and you complete enrollment to change your election no later than thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption).

The events that permit an election change and your election options are described in the section called *Changing Coverage*.

If you increase your contribution amount during the Plan Year due to a change in status, the increased amount you put in can be used only for expenses you incur after the date the change is effective.

FSA Debit Card

For your convenience, you may access your Health Care and Dependent Care FSA funds with a debit card (the "FSA Card"). The FSA Card can only be used for FSA Eligible Expenses, as described in this *Flexible Spending Accounts* section. When you use the FSA Card for Eligible Expenses, your Health Care or Dependent Care FSA is automatically debited to pay for such eligible expenses. You can use the FSA card at qualifying merchant locations that accept Visa®. Qualifying merchants include:

- Healthcare-related merchants, such as physician and dentist offices, hospitals, pharmacies, hearing, and vision care providers.
- Non-healthcare-related merchants, such as discount stores and grocery stores that have implemented an inventory information approval system (IIAS). The IIAS only allows eligible expenses to be purchased at these merchants. You can view a list of these merchants at sig-is.org.
- Your FSA Card may be used at Day Care providers that accept credit cards and have a valid merchant category code signifying they are a day care provider. The debit card may not be used if you pre-pay day care expenses since the IRS requires the expense must be incurred before reimbursement can be made from your dependent care spending account.

If you purchase services or items from a qualifying merchant, your transaction may be validated at the point of sale and the charges will be automatically deducted from your applicable Health Care or Dependent Care FSA. If you purchase eligible health care items along with non-qualifying items, be sure to ask the merchant to separate the eligible from the non-qualifying, otherwise your card will not work. Also, your FSA Card will stop working once you deplete the total amount of funds you elected for the Plan Year. Your card transactions can be viewed online at wexbenefitsyou.com/bjc/.

You are not required to use the FSA Card. You can choose at the point of sale whether to use it. Be sure to select "credit" when using your FSA Card—no PIN is necessary. Use of your FSA Card means that you have read and agree to comply with all of the terms and conditions for use of the card. These terms include, but are not limited to, your certification, without limitation, that at the time of enrollment and with each transaction, you will use the card only for qualified eligible expenses, that the expense paid with the card has not been reimbursed, that you will not seek

reimbursement from any other plan, and that you agree to reimburse the Plan for any unsubstantiated expenses reimbursed by the FSA.

Your use of the FSA Card is also subject to the following:

- Purchases that exceed the available funds in your Health Care or Dependent Care FSA will be declined, and you will have to use another form of payment and submit a claim for reimbursement. See the *Requesting Reimbursement* section below.
- Payment of expenses with the FSA Card is conditional. This means that if additional information is needed to verify your expense, payment from your FSA is considered conditional until the required documentation is received by the Benefits Manager.
- Use of your FSA Card that is contrary to the terms of the Plan may constitute fraud and will be treated accordingly by BJC.

Debit Card Claims Substantiation Requirements

Even though you do not have to submit a claim for reimbursement when you use your FSA Card, you may be required to provide documentation of your expenses in order to satisfy IRS requirements (also sometimes referred to as substantiation). Therefore, you should keep copies of all receipts and itemized statements (not just the credit card receipt) and explanation of benefits (EOBs) for each purchase or health care service throughout the Plan Year. An acceptable itemized receipt would include the merchant name, the name of the item/product/service, the date, and the amount of purchase.

Debit Card Substantiation File

The Debit Card Substantiation File refers to the monthly claims' files that BJC's medical, dental and vision Plans send to automatically substantiate debit card transactions that may require documentation. The Debit Card Substantiation File decreases the number of Health Care FSA claims that need substantiation.

Many of your other expenses purchased using the FSA Card may not require additional documentation to substantiate payment. For example:

- If the dollar amount of the Health Care FSA transaction at a health care provider equals the dollar amount of your co-payment, no additional documentation will be required.

If the expense for a qualifying health care expense is recurring and the amount, provider and duration matches an expense that has been previously approved, no additional documentation will be required. This would include an expense such as a prescription refilled on a regular basis from the same pharmacy and for the same charge. If the Benefits Manager cannot confirm that an expense paid for with the FSA Card was an eligible FSA expense or is not substantiated using the Debit Card Substantiation File, the Benefits Manager will notify you, requesting you to provide documentation, such as an itemized receipt or EOB, to substantiate your expense within a specified period of time. If the Benefits Manager determines that the expense paid with your FSA Card was not an eligible expense, is not substantiated using the Debit Card Substantiation File, or if acceptable substantiation is not received, your FSA Card will be deactivated. In order to reactivate your card, you must either:

- Submit a claim for reimbursement for one or more eligible expenses incurred during the Plan year that are at least equal in amount to the amount of the ineligible expense. The items or services cannot have been purchased with the FSA Card and cannot have been previously reimbursed.
- Repay the amount of the ineligible expense by personal check or money order.

If you fail to take either of these steps, the amount of the improper payment may be recouped from future claims submissions or withheld from your pay in accordance with all applicable laws.

You may appeal any determination in accordance with the Plan's *Claims Appeal Procedures – Flexible Spending Accounts (FSAs)* section of this SPD.

Requesting Reimbursement

If you do not use your FSA Card to pay for an eligible expense, you can request reimbursement for eligible claims either online via the WEX's website, mobile app, or by mailing reimbursement claims forms directly to WEX. You can access WEX's website at wexinc.com and obtain the FSA claim form. Claims can be faxed to 1-866-451-3245 or can be mailed in a sealed, confidential envelope and addressed to:

WEX, Inc.
P.O. Box 2926
Fargo, ND 58108-2926

During the course of the Plan Year, you may submit requests for reimbursement of expenses you have incurred. Expenses are considered "incurred" when the service is performed, not necessarily when it is paid for. If the request qualifies as a benefit or expense that the Plan has agreed to pay, you will receive a reimbursement payment soon thereafter. Remember, these reimbursements, which are made from the Plan, are generally not subject to federal income tax or withholding. Nor are they subject to Social Security taxes. You will only be reimbursed from the Dependent Care Flexible Spending Account to the extent that there are sufficient funds in the Account to cover your request.

You should submit all reimbursement claims during the Plan Year. For both the Health Care and Dependent Care Flexible Spending Accounts, you must submit claims no later than ninety (90) days after the end of the Plan Year. Any claims submitted after that time will not be considered.

For any questions regarding claims reimbursement, please contact WEX's Customer Service at: 1-866-451-3399.

Reimbursements are subject to the following:

- Completed claims are processed within two (2) business days from receipt. You may elect to have your reimbursements direct deposited by completing the necessary paperwork and submitting to WEX. Direct Deposit information can be found online at wexinc.com.
- If your claims exceed the balance in your Dependent Care FSA, you will be paid only as much as is in your account at the time. The remainder of the claim will be held until your account balance increases due to your continued contributions.
- Claims submitted for the Health Care FSA will be reimbursed, provided the expenses are eligible and do not exceed the amount of your election for the entire Plan year plus any amounts carried over from the prior Plan year minus reimbursements already made.
- When you submit your claim for reimbursement under the Health Care FSA, you may include a copy of the Plan's Explanation of Benefits (EOB) and/or other documentation for the expenses.
- You can view your account by accessing wexinc.com.
- Expenses from a given Plan Year must be paid with money deposited in your FSA that year (including your eligible Health Care FSA and Dependent Care FSA carryover amount from the prior Plan Year). However, you must submit expenses for reimbursement by the last day of March of the year following the year in which expenses were incurred. For example, if you incur an eligible expense in late December 2021, you have until March 31, 2022, to submit it for reimbursement. After March 31, 2022, however, your 2021 account is closed, and any remaining amounts equal to or greater than $50 will carry over to the next Plan Year.

Claims Appeal Procedures – Flexible Spending Accounts (FSAs)

Initial Claims Determinations

Once you have submitted your claims in the manner indicated in the Requesting Reimbursement section above, the Benefits Manager will decide your claim within a reasonable period of time, but not later than thirty (30) days after a claim is received. This time period may be extended for an additional fifteen (15) days when necessary due to matters beyond the control of the benefits coordinator or if your claim is incomplete. You will be advised in writing of the need for an extension during the initial 30-day period and a determination will be made no more than forty-five (45) days after the date the claim was submitted. If the extension is needed because your claim is incomplete, the notice will describe

specifically the information necessary to complete the claim and you will be allowed forty-five (45) days from receipt of the notice to provide the information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

If Your Claim Is Denied

If your claim for a benefit is denied in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
- Your right to submit written comments and have them considered.
- Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- If the claim denial relied on an internal rule, guideline, protocol, or other similar criterion in denying your claim:
    - A description of the specific rule, guideline, protocol, or criterion relied on, or
    - A statement that a copy of such a rule, guideline, protocol, or criterion will be provided free of charge upon request.

Review of Denied Claims

You have one hundred eighty (180) calendar days after receiving notice that your Health Care FSA claim has been denied in whole or in part in which to appeal the determination. You have sixty (60) calendar days after receiving notice that your Dependent Care FSA claim has been denied in whole or in part in which to appeal the determination. The appeal must be in writing and must be submitted to the Benefits Manager at the following address:

WEX, Inc.
P.O. Box 2926
Fargo, ND 58108-2926

If you do not file an appeal within this time period, you will lose the right to appeal the determination.

Your written appeal should set out the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate.

At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

A person not involved in the original claim denial will review and decide your appeal within a reasonable period of time, but not later than thirty (30) days after it is submitted. If you are not satisfied with the decision, you must submit a second level appeal to the BJC Plan Administrator in care of the Benefits Manager. Your second level appeal request must be submitted within sixty (60) days from receipt of the first level appeal decision and must be in writing. Your second level appeal must be submitted to the address shown below and the appeal will be forwarded, along with information that the Benefits Manager has regarding the first level appeal, to the BJC Plan Administrator for final determination.

The address for submitting a second level appeal is:
BJC Plan Administrator
c/o WEX, Inc.
P.O. Box 2926
Fargo, ND 58108-2926

A determination will be made by the Plan Administrator no more than thirty (30) days after your second level appeal is received.

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not afford deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

You will be notified in writing of the decision on appeal. If the decision upholds the initial denial of your claim, the notification will provide, among other things, the specific reason or reasons for the denial and other information required by ERISA, including your right to pursue legal action.

The decision of the Plan Administrator is final and binding on all individuals dealing with or claiming benefits under the Plan.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described in this section. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT (AD&D) INSURANCE

Life and AD&D Insurance Options

If you work to provide income for your family members, you want to make sure that they are protected financially in the event of your death or serious injury. BJC's flexible benefits program lets you choose the amounts and type of coverage that are best for you and the people you care about. The benefits program helps you protect your loved ones through plans that include:

- **A life insurance and accidental death and dismemberment (AD&D) insurance plan**. BJC provides a basic life and AD&D insurance benefit at no cost to eligible employees. * By electing supplemental life insurance and AD&D coverage, you can choose the life insurance level that you feel is best for providing long-term financial security for your family or other beneficiaries.
- **A dependent life insurance plan.** BJC gives you options to cover your spouse and eligible children for life insurance benefits.
- **An additional AD&D plan.** This lets you purchase additional accidental death and dismemberment protection if you choose.

As of January 1, 2013, the basic life and AD&D insurance, supplemental life and AD&D insurance, additional AD&D insurance and dependent life insurance coverages are provided by, and insured through, ReliaStar Life Insurance Company (a member of the Voya® family of companies).

*Basic life and AD&D is limited to $50,000 for directors and above if eligible for other life insurance in the Executive Benefits program.

Eligibility and Enrollment Process

Employee Eligibility

You are eligible to participate in the basic and supplemental life and AD&D insurance plans and the additional AD&D insurance plan if, regardless of retroactive reclassification, you are classified as:

- a regular full-time employee who works at least thirty-five (35) hours per week (seventy (70) hours per pay period), or
- a regular part-time employee who works at least twenty-four (24) hours per week (forty-eight (48) hours per pay period).

Temporary, PRN and per diem employees are not eligible to participate in the life and AD&D Plans.

For purposes of initial eligibility, the term “works” within this SPD means the budgeted hours in BJC’s payroll system, not the hours actually worked. In order to maintain and continue eligibility for life and AD&D insurance coverages described herein after your initial eligibility date, you must continue to actually work a minimum of: thirty-five (35) hours per week (seventy (70) hours per pay period) if you are a regular full-time employee or twenty-four (24) hours per week (forty-eight (48) hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare’s payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee’s audit to update an employee’s eligibility status based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include PTO, STD, low census, and unpaid approved leave hours.

Dependent Eligibility

If you are an eligible employee, you may also cover your eligible dependents through the dependent life insurance plan and the additional AD&D insurance plan's family coverage option. Your eligible dependents include:

- Your spouse. For purposes of the life and AD&D plans described in this SPD, an individual will be treated as your "spouse" only if you and such individual are lawfully married (as determined under applicable law at the time and location where the marriage was performed). The marriage must be memorialized by a marriage certificate issued by an entity entrusted with the appropriate legal authority to recognize such marriage.
- Your children up to age 26 who do not provide more than one-half of their own support during the year.
- Your physically or mentally disabled child of any age, provided the disability began before he or she reached the limiting age (26) for coverage by the Plan. The child must be unmarried, unable to engage in any substantial gainful activity and financially dependent upon you.

To continue coverage for a permanently disabled child, you must provide proof of the disability within thirty-one (31) days of the date your child reaches the limiting age. After the first two years, the insurance company will ask for proof when needed but not more than once per year.

Your eligible dependents do not include any spouse or child(ren) living outside the United States.

For purposes of the Plan, "child" means your natural child (from date of live birth), step-child, legally adopted child, or child placed with you for adoption who resides with you. It also includes any other child (including a grandchild) for whom you have been awarded legal custody or legal guardianship as long as he or she lives with you and receives over one-half of his or her support from you.

In a situation where you and your spouse are both eligible employees, only one of you may cover a dependent child. In addition, an employee may not be covered as a dependent spouse.

Enrollment Process

You are automatically enrolled for basic life and AD&D coverage (BJC-employer paid). If you wish to enroll for supplemental life, supplemental AD&D, additional AD&D and/or dependent life coverage, you must complete your enrollment no later than thirty-one (31) days after your hire date. For this purpose, your "hire date" means the date you are first classified as an employee in the payroll system. If you experience a qualified change in status event as indicated in the *Changing Coverage* section of this SPD, you must complete your enrollment no later than thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption). You and/or your dependents may be subject to evidence of insurability requirements, depending on the amounts and coverage elected. See the following sections regarding life and AD&D coverage for additional details.

Also, you may be eligible to enroll in these programs during the designated Annual Enrollment process for BJC. Follow the instructions provided by the BJC Benefits Department and review your annual enrollment materials. Again, you and/or your dependents may be subject to evidence of insurability requirements.

Be sure to examine your confirmation statement carefully to ensure that what you elected during enrollment is reflected on your confirmation statement. If it does not match, you must contact your local HR department within the thirty-one (31) days after your hire date to correct the error. If you do not contact your local HR department in a timely manner, the benefits reflected on your confirmation statement will be locked in, and you will not be permitted to change your coverage until the next annual enrollment period for the subsequent Plan year, unless you experience a change in status event as described in this SPD.

If you wish to enroll after the initial thirty-one (31) day period, as applicable, you will have to wait until the next annual enrollment period and provide satisfactory evidence of insurability. The effective date of your supplemental life and AD&D coverage, additional AD&D coverage, and/or dependent life coverage may be delayed if evidence of insurability is required.

If You Change BJC Employers

If you are covered by the Plan when you change employment to another BJC HealthCare participating employer (set forth in the *Plan Administration* section of this summary plan description) that offers coverage, your coverage will be continuous. You may change plan options only if your new employer does not offer the plan option in which you were enrolled on the date you changed employers. Otherwise, you will have to wait until the next annual enrollment.

Certificates of Coverage from Insurance Carrier

The life and AD&D insurance coverages are fully-insured under insurance policies described in the *Plan Administration* section of this SPD. The life and AD&D insurance benefits are described in the insurance carrier's Certificates of Coverage. The Certificates of Coverage summarize and explain the life and AD&D insurance benefits, when coverage begins, when benefits begin and end, and coverage and benefit limitations and exclusions, and are made a part of this SPD.

The Certificate of Coverage booklet "B-13620" describes the basic life and AD&D, supplemental life and AD&D, and dependent life coverages available to eligible physicians, full-time nurse practitioners, and full-time physician assistants employed by Physician Groups, L.C., Fairview Heights Medical Group, S.C., or Missouri Baptist Hospital of Sullivan.

The Certificate of Coverage booklet "B-13725" describes the basic life and AD&D, supplemental life and AD&D, and dependent life coverages available to all other eligible employees described in the *Employee Eligibility* section above.

The Certificate of Coverage booklet "B-13624" describes the additional AD&D coverages available to all eligible employees described in the *Employee Eligibility* section above.

NOTE: Please keep your applicable Certificate(s) of Coverage with this SPD for a description of your life and AD&D insurance benefits.

When Your Life, AD&D and Dependent Life Coverage Ends

Your basic and supplemental life and AD&D, additional AD&D and dependent life coverage will end on the earliest of the following dates:

- Any termination date described in the Certificate(s) of Coverage.
- The last day of the month in which you end active employment or otherwise cease to be a benefit eligible employee.
- The last day of the period for which you make a premium payment for dependent life coverage if the next payment is not made.
- The last day of the period for which your final contribution is made.
- The last day of the month following the date you submit notice to drop due to a change in status event, provided you do so within thirty-one (31) days of the date of the event.
- Immediately, if you make a material misrepresentation or otherwise commit fraud against the Plan. Such actions may include, but are not limited to, furnishing incorrect or misleading information to the Plan. Coverage will be terminated as of the date such misrepresentation or fraud occurred and the Plan also may recover the reasonable and customary charges for covered services provided to you or your covered dependent from you.
- The date on which the Plan ends, the insurance contract is terminated, or your employer no longer provides dependent life insurance benefits.
- With respect to AD&D coverage, the date the individual is on active full-time duty in the armed forces.

Dependent life coverage of any individual dependent will end on the earliest of:

- Any termination date described in the Certificate(s) of Coverage.
- the date your coverage ends as described above,

- the last day of the month following the date you submit a timely notice to drop such dependent's coverage, due to a change in status event, or
- the last day of the month in which such dependent ceases to meet the definition of dependent as described in the *Dependent Eligibility* section.

Additional AD&D coverage for dependents will end on the earliest of:

- Any termination date described in the Certificate(s) of Coverage.
- the date your own coverage ends, as described above,
- the date the dependent ceases to be eligible, or
- the date the dependent is on active full-time duty in the armed forces.

During a leave of absence that is approved according to BJC's established leave policies, you may be eligible to continue your life, AD&D, and/or dependent life insurance by paying the required premium contributions. If you do not continue coverage while on leave, waiting periods and/or requirements for evidence of insurability may apply if you decide to re-enroll when you return to work. However, you may reinstate your coverage without restrictions when you return to work following a leave approved under the Family and Medical Leave Act of 1993. Contact the Employee Service Center at 314-362-2184/855-362-2184 for more information.

Evidence of Insurability

Evidence of insurability (EOI) is required if you elect any amount of supplemental life insurance greater than $500,000. Where evidence of insurability is required, in no event will supplemental life coverage in excess of $500,000 be effective until such EOI is approved by the insurance company and the insurance company notifies the Plan Administrator.

Evidence of insurability (EOI) is required if you elect any amount of spouse dependent life insurance greater than $60,000. Where evidence of insurability is required, in no event will supplemental life coverage in excess of $60,000 be effective until such EOI is approved by the insurance company and the insurance company notifies the Plan Administrator.

You must also provide EOI if: (i) you and/or your spouse try to increase coverage during annual enrollment or due to a “change in status” (see the sections entitled *Changing Your Life and AD&D Insurance Coverage* and *Changing Your Dependent Life Insurance Coverage)*; or (ii) you and/or your spouse do not enroll when first eligible. Where EOI is required, in no event will any such coverage be effective until such EOI is approved by the insurance company and the insurance company notifies the Plan Administrator.

Coverage Costs

Basic and Supplemental Life and AD&D Coverage

If you are an eligible employee, BJC provides you with a basic level of life and AD&D insurance at no cost to you. If you select a higher level of life and AD&D benefits, the additional cost will be deducted from your paycheck on a pre-tax basis.

If you choose a life insurance amount of more than $50,000, the IRS requires that the cost of coverage over $50,000 be considered taxable income. The cost is calculated according to a table that uses rates established by the IRS based on age. This taxable income will show up on each paycheck you receive during the calendar year.

Additional AD&D Coverage

If you select additional AD&D coverage, the premium will be deducted from your paycheck on a pre-tax basis.

Dependent Life Coverage

Tax rules require that dependent life insurance be paid on an after-tax basis.

The Pre-Tax Advantage

You pay for many of your BJC benefits, including supplemental life and AD&D benefits, on a pre-tax basis. This means the cost of your contributions are taken from your pay before federal and state income taxes are deducted. This lowers your pay, which means you owe less in taxes. There are some important facts you should be aware of regarding this special tax break:

- In exchange for the tax break, the IRS generally requires that your annual benefit elections for pre-tax benefits will be locked in for the entire calendar year. There are exceptions to this rule if you have a qualifying status change during the year, as described in the *Changing Coverage* section.
- Benefits that are based on the amount of your annual earnings, such as your disability, life and accidental death and dismemberment insurance, are generally not affected by your pre-tax deductions. These benefits are based on your total, unreduced base pay.
- Under federal law, you do not pay Social Security (FICA) taxes on the pre-tax money you set aside for benefits. You should be aware that this could mean reduced benefits when you become eligible for Social Security. This reduction is generally very small, however, and may be outweighed by your current tax savings.

Naming a Beneficiary

You should designate a beneficiary to receive the benefits in the event of your death. You may designate a different beneficiary at any time by completing the beneficiary-designation section on myBJCnet. The beneficiary(s) you designate will apply to basic life and AD&D, supplemental life and AD&D, and additional AD&D insurance.

Life and AD&D

If you die, the amount of life insurance coverage you have selected will be paid to the beneficiary you designate. AD&D insurance pays a benefit to your beneficiary if you die, or to you if you sustain certain types of injuries as the result of an accident.

The applicable Certificate of Coverage will describe what happens if your beneficiary is not living at the time you die, or you do not name a beneficiary.

Dependent Life

You are automatically the beneficiary of your dependent’s life insurance coverage. No beneficiary designation is necessary. The applicable Certificate of Coverage will describe what happens if you are not living at the time benefits will be paid.

Additional AD&D

You are automatically the beneficiary for your dependents' AD&D benefits.

Changing Your Life and AD&D Insurance Coverage

You will be allowed to change your life insurance amount during the annual enrollment period for the subsequent Plan year. Your change will become effective the following January 1, subject to applicable evidence of insurability requirement. If you wish to increase coverage during the annual enrollment period, you must provide evidence of insurability to the insurance carrier, if applicable. If approved, coverage will be effective the first of the month following the approval date and notification to the Plan Administrator.

The only other time you will be permitted to change your elections is if you have a life event that qualifies as a “change in status” under IRS rules. For example, you may increase or decrease your life insurance coverage because of a marriage, birth, adoption, divorce, death or change in your spouse’s employment. Any change in coverage must be on account of and consistent with the change in status. The Plan Administrator has sole authority to determine whether an event qualifies as a change in status and whether any coverage change is on account of and consistent with that event. See the section *Changing Coverage* for more information. If you would like to change your coverage, contact your local

HR department to find out if your situation qualifies as a change in status. You must complete and submit your election change (written or online) within thirty-one (31) days of the event (sixty (60) days if the event is your child's birth, adoption, or placement for adoption).

During annual enrollment or if you have a change in status, you will be allowed to change your life insurance and AD&D choice. You may increase your coverage if you provide evidence of insurability and it is approved by the insurance company.

You also must provide evidence of insurability for any amount of life insurance over $500,000.

NOTE: Where evidence of insurability is required, in no event will coverage in excess of $500,000 be effective until such evidence of insurability is approved by the insurance company and the insurance company notifies the Plan Administrator. No one may be insured for more than $1.5 million.

Your change will become effective on the first day of the month following the date your coverage change is approved. However, if you are not actively at work on the date that increased benefits would otherwise become effective, the increase will not become effective for life insurance until the day after you return to active employment, and for AD&D until you return to active employment for at least thirty (30) consecutive days.

Changing Your Dependent Life Insurance Coverage

If you do not enroll for dependent life insurance within thirty-one (31) days of the date you or your dependents are first eligible, you will be required to provide evidence of insurability for a spouse you wish to enroll at a later date. If you elect "child only" coverage and wish to cover a spouse at a later date, you will be required to provide evidence of insurability for your spouse who was not previously covered. Evidence of insurability is not required for coverage of a child or children.

You may drop coverage or change coverage levels during the annual enrollment period. A change in dependent life coverage will become effective as follows:

- In the case of a change made during annual enrollment, on the next January 1st;
- In the case of a newly acquired dependent child, on the date of birth, adoption, or placement for adoption (as applicable), provided you submit your election change within sixty (60) days of the date of the child's birth, adoption, or placement for adoption;
- For all other change in status events, on the first day of the month after the date you submit your election change, provided you submit your election change within thirty-one (31) days of the date of the change in status event.

If evidence of insurability is required, coverage will not be effective until the first of the month after the insurance company approves the change and notifies the Plan Administrator. If you are not actively at work due to injury or sickness on the date that increased or additional benefits would otherwise become effective, the increase or additional benefits will be delayed until you return to active employment.

Claims Procedures and Appeals for Life and AD&D Insurance

Filing a Claim

To file a claim for benefits, you or your beneficiary should complete the appropriate forms that are available by calling the Employee Service Center at 362-2184/855-362-2184. BJC will mail you or your beneficiary the appropriate forms and provide you instruction on how to file the claim.

If the claim is based on death, written notice and proof of claim must be submitted to the insurance company no later than ninety (90) days after the date of death. If it is not possible to provide proof within this timeframe, proof must be provided as soon as reasonably possible. The insurance company may request an autopsy if not prohibited by applicable law.

If your claim is for AD&D benefits, the insurance company must receive written notice of your claim within twenty (20) days after your loss occurs. Within fifteen (15) days of receiving this notice, BJC will mail a claim form to you or your

beneficiary. You or your beneficiary must provide proof of the claim within ninety (90) days after the date your loss occurred. If you or your beneficiary cannot meet these time limits for reasons beyond your or your beneficiary's control, the claim must be filed as soon as reasonably possible to receive benefits. Unless the insured person is legally incapacitated, written proof must be given within one year of the time it is otherwise due.

IT IS YOUR RESPONSIBILITY OR THE RESPONSIBILITY OF YOUR BENEFICIARY TO MAKE CERTAIN THAT ALL REQUIRED FORMS AND PROOF OF CLAIM ARE SUBMITTED TO THE INSURANCE COMPANY IN A TIMELY MANNER.

Initial Claims Determinations

If Your Claim is Based on Death or Dismemberment

The insurance company will make a determination on the claim within a reasonable period of time, but no longer than ninety (90) days after the claim is received unless special circumstances require extra time for processing. If such a time extension is necessary, you will receive written notice before the end of the initial ninety (90) days. This notice will tell you why additional time is needed and the date you can expect a final decision. This decision must be made within ninety (90) days after the end of the initial 90-day period.

If Your Claim is Based on Disability (Waiver of Premium)

If your claim involves a determination as to whether you are disabled, the insurance company will make a determination on your claim within a reasonable period of time, but not later than forty-five (45) days after a claim is received. This time period may be extended for an additional sixty (60) days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the insurance company. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues.

If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed forty-five (45) days from receipt of the notice to provide the additional information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

Notification

If claim is denied in whole or in part, you or your beneficiary will receive a written notice that includes:

- The specific reason or reasons for the denial.
- Reference to specific Plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
- Your right to submit written comments and have them considered.
- Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.

If your claim is based on disability, the notice will also include:

- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied on in denying your claim or, alternatively a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.

- If the denial was based on a medically necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgement for the adverse decision, or a statement that such explanation will be provided free of charge upon request.
- If applicable, the reasons for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.
- Notice in a culturally and linguistically appropriate manner.

Review of Denied Claims (Claims Appeals Procedures)

You must appeal any denial of your claim to the appropriate insurance company.

If your claim involves death or dismemberment, this appeal must be made in writing within 60 days after you receive the written notice from the insurance company that your claim had been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial. If your claim involves a determination of disability (waiver of premium), this appeal must be made in writing no more than one hundred eighty (180) days after you receive the written notice from the insurance company.

Your written appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

If Your Claim Is Based on Death or Dismemberment

The insurance company will make a decision on your appeal within a reasonable period of time but no longer than 60 days after it is submitted. This time period may be extended for an additional sixty (60) days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period and a determination will be made no more than one hundred twenty (120) days after the date the appeal was submitted.

If Your Claim Is Based on Disability (Waiver of Premium)

The insurance company will make a decision on your appeal within a reasonable period of time but no longer than forty-five (45) days after it is submitted. This time period may be extended for an additional forty-five (45) days if the insurance company determines that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 45-day period and a determination will be made no more than ninety (90) days after the date the appeal was submitted.

Review Standards

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. In addition, the individual who decides your appeal will not be the same individual who initially decided your claim and will not be that individual's subordinate.

The insurance company may consult with a health professional in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the initial benefit determination nor be a subordinate of the health professional who was involved.

If your claim is based on disability, before the insurance company issues a denial of an appeal, it will provide you any new or additional evidence it has or any new or additional rationale on which the denial is proposed to be based and provide you with a reasonable opportunity to respond.

Notification of Decision

You will be notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide:

- The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by the insurance company and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires.

If your claim is based on disability, the notice will also include:

- Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and
- Notice in a culturally and linguistically appropriate manner.

The decision of the insurance company is final and binding on all individuals dealing with or claiming benefits under the Plan.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claim procedures to "you" is intended to include your authorized representative.

SHORT-TERM DISABILITY

BJC offers Short-Term Disability (STD) coverage under the BJC HealthCare STD Plan that replaces some of your income if an Injury or Sickness prevents you from working. It is possible that an Injury or Sickness may keep you from working for more than five (5) days, perhaps a couple of weeks or more, which may result in your inability to financially support yourself or your family. The STD coverage is designed to help provide you with a portion of your income if you become Disabled and are unable to work for up to one hundred eighty (180) days.

BJC pays the entire cost of the STD coverage for eligible employees; STD coverage pays 60% of an eligible employee's weekly Covered Earnings, up to a maximum of $2,500 per week.

As of January 1, 2018, the Short-Term Disability coverage is administered by The Lincoln National Life Insurance Company, a Lincoln Financial Group company ("Lincoln").

Eligibility

Except as provided immediately below, you are eligible to participate in the BJC HealthCare STD Plan if, regardless of retroactive reclassification, you are classified as:

- a regular full-time employee who works at least thirty-five (35) hours per week (or seventy (70) hours per pay period), or
- a regular part-time employee who works at least twenty-four (24) hours per week (or forty-eight (48) hours per pay period).

Temporary, PRN, and per diem employees are not eligible to participate in the Plan. In addition, the following employees are not eligible to participate in the Plan: (1) medical resident house staff employees; (2) Directors who are eligible for benefits under the Salary Continuation Plan or who will become eligible for such benefits after satisfaction of any applicable waiting period; (3) Vice Presidents and above; and (4) physicians, hospitalists, nurse practitioners, physician assistants, and other mid-level providers, also referred to as Advanced Practice Practitioners (APP), employed by Physician Groups, L.C., Fairview Heights Medical Group, S.C., or Missouri Baptist Hospital of Sullivan who are eligible for benefits under the "Provider Salary Continuation Policy" or who will become eligible for such benefits after satisfaction of any applicable waiting period.

For purposes of initial eligibility, the term "works" within this SPD means the budgeted hours in BJC's payroll system, not the hours actually worked. In order to maintain and continue eligibility for STD coverage after your initial eligibility date, you must continue to actually work a minimum of: thirty-five (35) hours per week (seventy (70) hours per pay period) if you are a regular full-time employee or twenty-four (24) hours per week (forty-eight (48) hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare's payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee's audit, to update an employee's eligibility status based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include PTO, STD, low census, and unpaid approved leave hours.

When Coverage Begins and Ends

When Coverage Begins

If you are an eligible employee and have at least six (6) months of Active Service, you are automatically covered.

If you are a new hire, your coverage will be effective on: (1) the first day immediately following six (6) months of Active Service from your hire date; or (2) the first day immediately following the later of: (i) the date you become employed in an eligible group if you have six (6) months or more of Active Service with your participating employer, or (ii) the first day immediately following the date you become employed in an eligible group and the expiration of six (6) months of Active Service with your participating employer.

The six (6) months or more of Active Service required before coverage begins is known as the "Eligibility Waiting Period."

If you are rehired, a new Eligibility Waiting Period must be satisfied. You are not required to satisfy a new Eligibility Waiting Period if your coverage ends under the Plan because you are no longer eligible but continue to be employed with a participating employer and within one (1) year become eligible again.

NOTE: No action on your part is required to enroll.

"Actively at Work" Requirement

If you are absent from work due to an Injury, Sickness, temporary layoff, or leave of absence on the day your coverage ordinarily would become effective, your coverage will be made effective on the date you return to active employment on a full-time basis (thirty-five (35) hours per week or seventy (70) hours per pay period) or part-time basis (twenty-four (24) hours per week or forty-eight (48) hours per pay period) for a full day.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The date you cease to be Actively at Work unless Active Service ceases during a temporary layoff or approved leave of absence, provided that coverage will not continue more than six (6) months from the date you stopped Active Service.
- The date you are no longer eligible for coverage.
- When you are able to work under a Transitional Work arrangement and you refuse to do so without Good Cause.
- The date the Plan is terminated.
- The date you fail to comply with the terms and conditions of the Plan (including, but not limited to, this SPD).

Notwithstanding the above, your coverage may be continued during a leave of absence granted under the Family and Medical Leave Act of 1993 (FMLA).

Continuation of Coverage if You Are Disabled

If your coverage under this Plan ends because your employment ends, or you are no longer eligible, and you are Disabled, your coverage due to your Disability will be continued until the Disability ends or when benefits are no longer payable, whichever comes first. Coverage that is continued under this provision is subject to all other terms of the *When Coverage Ends* section of this SPD.

Coverage Costs

The coverage is provided at no cost to you. BJC provides the STD coverage.

The entire amount of any Short-Term Disability (STD) benefit you receive will be subject to income tax.

Schedule of Benefits - Short-Term Disability (STD)

The BJC HealthCare STD Plan offers the following options:

COVERAGE AMOUNT	MAXIMUM WEEKLY BENEFIT	AVAILABLE TO
60% of weekly Covered Earnings	$2,500	All eligible regular full-time and part-time employees

Your benefit will be coordinated with payments you receive from other sources, such as Social Security. This is explained in the section called *Coordinating with Other Income-Replacement Benefits*.

For purposes of this Plan, "Covered Earnings" means your base wage or salary as determined by BJC for work performed for your participating employer as in effect just prior to the date the Disability began. Covered Earnings do not include commissions, bonuses, overtime pay, and other premium pay or extra compensation. Covered Earnings are determined initially on the effective date of your coverage. A change in the amount of Covered Earnings is effective on the date of the change. Any increase or decrease in your Covered Earnings will not be effective during a period of continuous Disability.

If you become Disabled while you are on a temporary layoff or approved leave of absence, your base weekly Covered Earnings in effect immediately prior to your layoff or leave is used in determining your weekly Disability Benefit.

Disability benefits are based on seven (7) calendar days in a work week. Disability benefits will be prorated if payable for any period less than a 7-day week. If you are working while Disabled, the Disability benefit will be the Return to Work Incentive Benefit.

If You Change BJC Employers

If you are covered by the Plan when you change employment to another BJC HealthCare participating employer, your coverage will be continuous (subject to the limitations of that employer's plan).

When Benefit Payments Begin and End

When Benefits Begin (After Elimination Period)

Unless otherwise provided herein, your STD Elimination Period is five (5) calendar days. This means that you will be eligible to receive weekly Disability benefits only after you have been Disabled for five (5) consecutive calendar days. You must be under the regular and Appropriate Care of a Physician and submit proof of your Disability acceptable to the Plan. During your Elimination Period and any days of Disability following the Elimination Period, you will be required to use any available PTO in accordance with the then-current BJC HealthCare PTO Policy 4.01 (or other applicable PTO Policy) to supplement your Disability benefits under the Plan. PTO will automatically be applied to all STD leaves until your PTO bank is exhausted.

When Benefits End

Your benefits will end on the earliest of:

- When you are able to work under a Transitional Work arrangement and you refuse to do so without Good Cause.
- The date your Disability Earnings from any occupation exceed the amount allowable under the Plan.
- The end of the maximum period of payment as described in this SPD.
- The date you are no longer Disabled under the terms of the Plan.
- The date you fail to submit proof of continuing disability, including refusal to be examined by a Physician or to be interviewed by a plan representative.
- The date you fail to cooperate with the administration of your claim. Such cooperation includes, but is not limited to, providing any information or documents needed to determine whether benefits are payable or the actual benefit amount due.
- The date you die.
- The date you cease to be under the regular and Appropriate Care of a Physician.

Benefits may be resumed if you begin to cooperate fully in the Transitional Work arrangement within thirty (30) days of the date benefits terminated.

Definition of Disability

You will be considered Disabled if you are unable to perform the Material and Substantial Duties of your Regular Occupation at your regularly assigned schedule of budgeted hours because of Sickness or Injury and are unable to earn 80% or more of your Covered Earnings due solely to the same Sickness or Injury.

You must be under the regular and Appropriate Care of a Physician during your Disability. The Plan will require proof of earnings and continued Disability.

Physical Examination and Autopsy

The Plan, at its expense, has the right to examine you as often as it may reasonably require if you have a pending claim. Also, the Plan may, at its expense, require an autopsy unless prohibited by law.

Disability Benefits

The Plan will pay Disability benefits if you become Disabled while covered under this Plan. You must satisfy the Elimination Period, be under the regular and Appropriate Care of a Physician and meet all the other terms and conditions of the Plan. You must provide the Plan, at your own expense, satisfactory proof of Disability before benefits may be paid. The Disability benefit is described in the *Schedule of Benefits – Short-Term Disability (STD).*

The Plan will require continued proof of your Disability for benefits to continue.

Payment of Benefits

Calculating Your Weekly Benefit

Your Disability benefit for any week you are entitled to a benefit is your Gross Disability Benefit minus Other Income-Replacement Benefits.

- "Gross Disability Benefit" is the lesser of: 60% of your base weekly Covered Earnings (rounded to the nearer dollar) or the Maximum Weekly Disability Benefit.
- "Other Income-Replacement Benefits" means any benefits listed in the *Coordinating with Other Income-Replacement Benefits* provision that you receive on your own behalf or for dependents, or which your dependents receive because of your entitlement to Other Income-Replacement Benefits.

NOTE: If you are working while Disabled, your Disability benefit will be calculated as described in the *Return to Work Incentive Benefit* and *Return to Work Incentive Benefit Calculation* (as described below), not the Disability benefit calculation described above.

You can follow these steps to calculate the amount of your monthly benefit.

Step 1

Take 60% of your base weekly Covered Earnings, or $2,500, whichever is less.

Step 2

Subtract the amount of the "Other Income-Replacement Benefits" described below.

Example

Suppose John became Disabled due to an Injury while covered under the Plan. John's current base weekly Covered Earnings is $500 per week, so his short-term Disability benefit will be 60% of $500, or $300. If he receives a $100 weekly disability benefit from Social Security, the Plan would pay the remaining $200 each week, for a total combined weekly income of $300.

However, if you are working at your job or some other job while Disabled, your Disability benefit will be as explained in the section Return to Work Incentive Benefit.

Coordinating with Other Income-Replacement Benefits

In addition to this STD Plan, you and/or your dependents may also be eligible for other benefits (whether or not disability-related) from plans and/or certain laws that provide replacement of income. To prevent duplication, your Disability benefit under this Plan will be reduced by the amount of such other income-replacement benefits. For example, if you are receiving Social Security benefits (retirement or disability), which began on or after your date of disability, your

benefit under this STD Plan will be reduced by such Social Security benefits. Sources of income-replacement benefits include, but are not limited to:

- unemployment benefits;
- any amounts received (or assumed to be received) * by you or your dependents under:
  - the Canada and Quebec Pension Plans;
  - the Railroad Retirement Act;
  - any local, state, provincial or federal government disability or retirement plan or law payable for Injury or Sickness provided as a result of employment with your Employer;
  - any salary continuation plan of your Employer;
  - any work loss provision in mandatory "No-Fault" auto insurance;
- any Social Security disability benefits which begin on or after your disability date, or retirement benefits you or any third party receives (or is assumed to receive*) on your own behalf or for your dependents; or which your dependents receive (or are assumed to receive*) because of your entitlement to such benefits; however, eligibility for "reduced" Social Security retirement benefits (those you can elect to receive at age 62) will generally not affect your STD benefit amount, unless you actually apply for and receive such benefits;
- any Retirement Plan (including early retirement benefits if you elect to receive them). "Retirement Plan" means any defined benefit or defined contribution plan sponsored or funded by your Employer. It does not include profit-sharing or deferred compensation plans; any other retirement or savings plan maintained in addition to a defined benefit or other defined contribution plan, or any employee savings plan including a thrift, stock option or stock bonus plan, individual retirement account (IRA), individual tax-sheltered annuity, or 401(k) or 403(b) plan;
- any amounts paid because of loss of earnings or earning capacity through settlement, judgment, arbitration or otherwise, where a third party may be liable, regardless of whether liability is determined; and
- Any other group insurance policy for another employer that you become covered under while you are disabled under this Plan.

Dependents include any person who receives (or is assumed to receive) benefits under any applicable law because of your entitlement to benefits.

*See the *Assumed Receipt of Benefits* provision.

Increases in Other Income Benefits

Any increase in Other Income-Replacement Benefits during a period of Disability due to a cost of living adjustment will not be considered in calculating your Disability benefits after the first reduction is made for any Other Income-Replacement Benefits. This section does not apply to any cost-of-living adjustment for Disability Earnings.

Lump Sum Payments

Other Income-Replacement Benefits or earnings paid in a lump sum will be prorated over the period for which the sum is given. If no time is stated, the lump sum will be prorated over five (5) years. If no specific allocation of a lump sum payment is made, then the total payment will be an Other Income-Replacement Benefit.

Assumed Receipt of Benefits

The Plan will assume you and your dependents are receiving benefits for which you are eligible from Other Income-Replacement Benefits. Your Disability benefits will be reduced by the amount from Other Income-Replacement Benefits the Plan estimates are payable to you and your dependents.

The Plan will not assume receipt of any pension or retirement benefits that are actuarially reduced according to applicable law, until you actually receive them.

If you submit satisfactory proof that you have: (i) applied for such Other Income-Replacement Benefits; (ii) completed or exhausted all appeals (unless the Plan determines that further appeals are not likely to succeed); and (iii) officially

been denied these Other Income-Replacement Benefits, and you sign a reimbursement agreement with the Plan, the Plan will waive the Assumed Receipt of Benefits of such Other Income-Replacement Benefits, except for Disability Earnings for work you perform while Disability benefits are payable. If you actually receive more than the estimated amount, the Plan may recover any overpayment of STD benefits.

The Plan may limit its waiver of Assumed Receipt of Benefits at its discretion.

Return to Work Incentive Benefit

You may work for wage or profit while you are Disabled. In any week in which you work, and a Disability benefit is payable, the Return to Work Incentive Benefit Calculation applies.

Return to Work Incentive Benefit Calculation

For each week that the Return to Work Incentive Benefit Calculation applies, your Disability benefits will be calculated as follows:

1. Add your Gross Disability Benefit and your weekly Disability Earnings.
2. Compare the sum from 1. to your weekly Covered Earnings.
3. If the sum from 1. exceeds 100% of your weekly Covered Earnings, then subtract the weekly Covered Earnings from the sum in 1.
4. Your Gross Disability Benefit will be reduced by the difference from 3., as well as by Other Income-Replacement Benefits.
5. If the sum from 1. does not exceed 100% of your weekly Covered Earnings, your Gross Disability Benefit will be reduced by the Other Income-Replacement Benefits.

The Plan will, on a regular basis (e.g., weekly), review your status and will require satisfactory proof of earnings and continued Disability.

No Disability benefits will be paid, and your coverage under the Plan will end if the Plan determines you are able to work under a Transitional Work arrangement and you refuse to do so without Good Cause.

Minimum Benefit

Even if your STD Disability benefit is subject to reduction, you will still receive a minimum weekly benefit of at least $25.00. However, if there is an overpayment due, the minimum benefit may be reduced in order to recover the overpayment.

Overpayment of Benefits

The Plan has the right to recover any benefits it has overpaid. The Plan may use any or all of the following to recover an overpayment:

- request a lump sum payment of the overpaid amount;
- reduce any amounts payable under this Plan; and/or
- take any appropriate collection activity available to it.

The minimum benefit amount will not apply when Disability Benefits are reduced in order to recover any overpayment. If an overpayment is due when you die, any benefits payable under the Plan will be reduced to recover the overpayment.

How Long Benefits Are Paid (Maximum Period of Payment)

As long as you remain Disabled, your STD benefits will continue up to a maximum period of twenty-five (25) weeks after you have satisfied the Elimination Period.

You may be required to submit proof of continuing Disability indicating that you are under the regular and Appropriate Care of a Physician. This proof, provided at your expense, must be received in order for your benefit payments to continue.

Timing of Payment

Generally, Disability benefits will be paid at regular weekly intervals or as soon as administratively practicable. Any balance, unpaid at the end of any period for which the Plan is liable, will be paid at that time.

To Whom Payable

Disability benefits will be paid to you. If you are a minor or are declared by a court as incompetent or, in the opinion of the Plan, you are not able to give a valid receipt, such payment will be made to your legal guardian. However, if no request for payment has been made by your legal guardian, the Plan, may at its option, make payment to the person or institution appearing to have assumed custody and support.

If you die while any Disability benefits remain unpaid, the Plan may, at its option, make direct payment to any of the following living relatives of you: spouse, mother, father, children, brothers or sisters; or to the executors or administrators of your estate. The Plan may reduce the amount payable by any indebtedness due.

Payment in the manner described above will release the Plan from all liability for any payment made.

If You Become Disabled Again After You Return to Work (Successive Periods of Disability)

If you return to Active Employment in your Regular Occupation for your employer on a regular full-time or part-time basis, as applicable under your employer's budgeted payroll hours, for less than fourteen (14) consecutive days and you earn less than the percentage of Covered Earnings that would still qualify you to meet the definition of Disability/Disabled during at least one (1) week, your separate period of Disability will be considered continuous and will be treated as part of your prior claim (subject to all of the provisions of your prior claim) and you will not have to complete another applicable Elimination Period.

Any separate period of Disability which is not considered continuous is subject to all provisions of a new claim and you must satisfy a new Elimination Period. A period of Disability is not continuous if separate periods of Disability result from unrelated causes.

If you have a separate period of Disability and become entitled to benefits under any other group STD plan, you will not be eligible for benefits under this Plan.

Exclusions and Limitations

Exclusions

The Plan will not pay any Disability benefits for a Disability that results, directly or indirectly, from:

- intentionally self-inflicted Injury while sane.
- war or any act of war, declared or undeclared.
- active participation in a riot.
- the committing of or attempting to commit a felony.
- the revocation, restriction, or non-renewal of your license, permit or certification necessary to perform the duties of your occupation unless due solely to Injury or Sickness otherwise covered by the Plan.
- any cosmetic surgery or surgical procedure that is not medically necessary; "Medically Necessary" means the surgical procedure is: (a) prescribed by a Physician as required treatment of the condition, Injury or Sickness; and (b) appropriate according to conventional medical practice for the condition, Injury or Sickness in the locality in which the surgery is performed. (The Plan will pay benefits if the Disability is caused by you donating an organ in a non-experimental organ transplant procedure.)
- an Injury or Sickness for which you are entitled to benefits from workers' compensation or occupational disease law.
- an Injury or Sickness that is work related.

In addition, the Plan will not pay Disability benefits for any period of Disability during which you are incarcerated.

Claims and Appeal Procedures - STD

How to File a Claim

If you become Disabled, you may obtain instructions on how to report an STD claim from the BJC Total Rewards website. You may report an STD claim by calling the BJC Leave Management Center at 800-213-1580, or by completing an online claim at mylincolnportal.com. If you know you will be out longer than five (5) continuous calendar days, you should contact Lincoln on the first day of your absence. If you do not know how long you will be out, you should contact Lincoln as soon as possible after the fifth (5th) day. Claims not filed within one (1) year after proof is otherwise required will be denied unless the delay was due to the fact that you were not legally competent.

Before you call Lincoln or go online, please have this information handy:

- Your name, address, phone number, birth date, Social Security number and email address.
- Employment information, such as date hired and job title.
- The reason for your claim – Injury or Sickness.
- A description of your Injury or Sickness, symptoms, and/or diagnosis.
- Include the date your symptoms started and if you've had these symptoms before.
- Workers' compensation claims you've filed or plan to file.
- Details about Physician, hospital, or clinic visits, including dates and contact information.

After reporting the STD claim, Lincoln will send you a letter. It will include a copy of the recorded message for your records. It will also include a form that gives the insurance company permission to obtain additional information Lincoln may need to finish processing your STD claim. Sign and return that form as indicated in the letter. Also, check with your Physician to see if there are any other forms you need to complete and sign.

The Benefits Manager may call you and your participating employer for a list of your job requirements. The Benefits Manager may also call your Physician for your medical records. This information will help the Benefits Manager to estimate how long you may be out of work, and the benefits you may be eligible to receive.

If the Plan needs more information, you will be asked to provide it. The claims investigations are very thorough and may take some time. By filling out the claim forms as soon as possible, you help ensure your benefit check will not be delayed. Once your STD claim is accepted, you will receive your first STD benefits check, along with a letter explaining how your benefits were calculated.

As often as the Plan may reasonably require, you must provide written proof of your continued Disability and that you are receiving regular and Appropriate Care from a Physician. In addition, the Plan may require that you be examined by an independent Physician or other expert of its choice to determine the extent of any Injury or Sickness for which you have made a claim. More information about the Plan and your rights as a participant is included in the *ERISA Rights* section of this SPD.

Initial Claims Determinations

Lincoln will make a determination on STD claims within a reasonable period of time, but not later than forty-five (45) days after a claim is received. This time period may be extended for an additional sixty (60) days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the Plan. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues. If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed forty-five (45) days from receipt of the notice to provide the additional information. The timeframe for deciding the claim will be suspended from the date the notice

of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

If Lincoln denies your claim for a benefit in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered.
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied on in denying your claim or, alternatively a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.
- If the denial was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.
- A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim.
- Notice in a culturally and linguistically appropriate manner.

Review of Denied Claims (Appeals)

You must appeal any denial of your claim to Lincoln. This appeal must be made in writing within one hundred eighty (180) days after you receive the written notice that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

Your written appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Lincoln will make a decision on your appeal within a reasonable period of time but no longer than forty-five (45) days after it is submitted. This time period may be extended for an additional forty-five (45) days if special circumstances make an extension necessary. You will be advised in writing of the need for an extension during the initial 45-day period and a determination will be made no more than ninety (90) days after the appeal was submitted. If the extension is needed because you failed to submit information necessary to decide the appeal, the period for deciding the appeal shall be tolled from the date on which Lincoln sends you notification of the extension until the date on which you respond to the request for additional information.

The review by Lincoln will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

If the appeal involves claim denial based on medical judgment, it will be reviewed by a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was not consulted in connection with the initial claims denial and who is not a subordinate of any individual consulted. If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation

of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request. Any medical or vocational expense consulted in connection with your claims denial will be identified without regard to whether the advice was relied upon in making the decision. You have the right to review and to a reasonable opportunity to respond to any new or additional evidence considered, relied upon, or generated, or any new or additional rational in support of an adverse decision before an adverse decision is rendered on your appeal.

Notice of Decision

Lincoln's notice of denial shall include:

- The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;
- Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and
- Notice in a culturally and linguistically appropriate manner.

The decision of Lincoln is final and binding on all individuals dealing with or claiming benefits under the Plan.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

Glossary of STD Terms

Accident means a sudden, unforeseeable external event that causes bodily Injury to you while you are covered under the Plan.

Active Employment, Active Service, or Actively at Work with your employer means that you report to work at your usual place of employment or any other business location where you are required to travel, and that you are able to perform the Material and Substantial Duties of your Regular Occupation for the normal workday. You will be considered to be Actively at Work on a day that is not one of your employer's scheduled work days only if you were Actively at Work on the preceding scheduled work day.

You must be working at least the minimum number of hours for your class of employment and your work site must be your employer's usual place of business; an alternative work site at the direction of your employer, including your home; or a location to which your job requires travel. Normal vacation is considered Active Employment.

Appropriate Care means the determination of an accurate and medically supported diagnosis of your Disability by a Physician, or a plan established by a Physician of ongoing medical treatment and care of the Disability that conforms to generally accepted medical standards, including frequency of treatment and care.

Covered Earnings means your base wage or salary as determined by BJC for work performed for your participating employer as in effect just prior to the date the Disability began. Covered Earnings do not include commissions, bonuses, overtime pay, and other premium pay or extra compensation. Covered Earnings are determined initially on the effective date of your coverage. A change in the amount of Covered Earnings is effective on the date of the change. Any increase in your Covered Earnings will not be effective during a period of continuous Disability.

Disability Earnings means any wage or salary you receive for any work from BJC or any BJC employer during your Disability, including commissions, bonuses, overtime pay or other premium pay or extra compensation.

Elimination Period means a period of continuous disability which must be satisfied before you are eligible to receive benefits under the Plan.

Good Cause means a medical reason that reasonably prevents participation in a Transitional Work arrangement. Satisfactory proof of Good Cause must be provided to the Plan.

Injury means any accidental loss or bodily harm resulting directly from an accident and independently of all other causes.

Material and Substantial Duties means duties that are normally required for the performance of your Regular Occupation and cannot be reasonably omitted or modified.

Physician means a licensed doctor practicing within the scope of his or her license and rendering care and treatment to you that is appropriate for your condition and locality. The term does not include you, your spouse, your or your spouse's immediate family (including parents, children, siblings, or spouses of any of the foregoing, whether the relationship derives from blood or marriage), or a person living in your household.

Regular Occupation means the occupation you are routinely performing when your Disability begins. In evaluating Disability, the Plan will consider the duties of the occupation as it is normally performed for your BJC employer. If you are a Physician, you will not be considered Disabled solely because of the loss or restriction of your license to engage in your occupation.

Sickness means any physical or mental illness or disease.

Transitional Work means an arrangement under which your employer allows you to work with temporary restrictions in a modified, alternative, or reduced-hours capacity, for a defined, limited period of time, to accommodate Injury or Sickness which causes Disability. Transitional Work includes:

- modified work - changing or eliminating specific duties of your Regular Occupation;
- alternative work - another position (other than your Regular Occupation) which is consistent with any restrictions made necessary due to your Injury or Sickness; or
- reduced-hours - reducing the number of work hours per week.

LONG-TERM DISABILITY

BJC offers long-term disability (LTD) coverage which provides you a source of income if you become disabled. It is possible that a serious injury or sickness may keep you from working for a prolonged time, perhaps several months or more, which may result in your inability to financially support yourself or your family. The LTD coverage is designed to help provide you with a financial safety net if you become disabled and unable to work for more than one hundred eighty (180) days.

LTD coverage is administered and fully insured by The Lincoln National Life Insurance Company, a Lincoln Financial Group company ("Lincoln").

If you are in Classes 1, 3, 4A, 5, or 7 as described in the section titled *Classes of Employees* below, the Plan offers you the following coverage levels:

- If you are an eligible full-time employee and have six (6) months of service, you automatically receive level 1 LTD coverage from your participating employer. This pays you 60% of your base monthly pay, up to a maximum of $10,000 per month, while you are disabled.
- If you are an eligible part-time employee and have six (6) months of service, you can purchase the LTD coverage option of 60% by paying the full cost yourself.

If you are an eligible employee in Class 7C as described in the section titled *Classes of Employees* below, the Plan offers you the following coverage level:

- If you are an eligible full-time employee and have six (6) months of service, you automatically receive level 1 LTD coverage from your participating employer. This pays you 60% of your base monthly pay, up to a maximum of $15,000 per month, while you are disabled.

An eligible employee will be deemed to have six (6) months of service with the participating employer on the sixth month anniversary of the employee's date of hire if the employee is continuously employed by the participating employer on that date.

If you are an eligible employee in Classes 8, 9, or 10 as described in the section titled *Classes of Employees* below, you automatically receive the following coverage level:

- 60% of your base monthly pay, up to $15,000 per month.

Your coverage becomes effective as shown in your applicable Certificate of Coverage as described below.

Eligibility and Enrollment Process

Eligibility

You are eligible to participate in the long-term disability plan if, regardless of retroactive reclassification, you are classified as:

- a regular full-time employee who works at least thirty-five (35) hours per week (or seventy (70) hours per pay period), or
- a regular part-time employee who works at least twenty-four (24) hours per week (or forty-eight (48) hours per pay period).

Temporary, PRN, and per diem employees are not eligible to participate in the Plan.

For purposes of initial eligibility, the term "works" within this SPD means the budgeted hours in BJC's payroll system, not the hours actually worked. In order to maintain and continue eligibility for LTD coverage after your initial eligibility date, you must continue to actually work a minimum of: 35 hours per week (70 hours per pay period) if you are a regular full-time employee or 24 hours per week (48 hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare's payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee's audit, to update an employee's eligibility status

based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include PTO, STD, low census, and unpaid approved leave hours.

NOTE: For medical resident house staff employees ("residents"), your LTD benefits are different than those described in this SPD. Residents' LTD benefits are fully-insured by The Paul Revere Life Insurance Company ("Paul Revere"). Please refer to the BJC HealthCare LTD Plan Summary of Material Modifications ("SMM") to the Benefit Summary for Group Insurance Policy issued by Paul Revere ("Benefit Summary"). The SMM along with the Benefit Summary, which may be updated from time to time, serves as the applicable summary plan description (SPD) for details on the LTD benefits available to residents.

Enrollment Process – New Hire/Status Changes

If you are in Classes 3, or 4A and wish to enroll for LTD coverage, you must complete your enrollment within the thirty-one (31) day period immediately preceding your Eligibility Date. For this purpose, "Eligibility Date" means the date you have completed six (6) months of Active Service with your participating employer (also known as your "Eligibility Waiting Period"). If you are in Classes 1, 5, 7, 7C, 8, 9 or 10, coverage is automatically provided, and you do not need to enroll.

Annual Enrollment

Provided you will have satisfied your Eligibility Waiting Period by the following January 1st and are otherwise eligible, you can change your LTD coverage during the annual enrollment period. Your change will become effective the following January 1.

"Actively at Work" Requirement

If you are absent from work due to a Sickness, Injury, temporary layoff or leave of absence on the day your coverage ordinarily would become effective, your coverage will be made effective on the date you return to Active Employment on a full-time basis (thirty-five (35) hours per week or seventy (70) hours per pay period) or part-time basis (twenty-four (24) hours per week or forty-eight (48) hours per pay period) for a full day.

Once your coverage begins, any increased or additional coverage will take effect as described above if you are in Active Employment or if you are on a temporary layoff or approved leave of absence. If you are not in Active Employment due to Injury or Sickness, any increased coverage will begin on the date you return to Active Employment. Any decrease in coverage will also take effect on the date you return to Active Employment as described above but will not affect a payable claim for a period of disability that begins prior to the date of the decrease.

If You Change BJC Employers

If you are covered by the Plan when you change employment to another BJC HealthCare participating employer, your coverage will be continuous (benefit limits will continue to apply). You may change plan options only if your new employer doesn't offer the Plan option in which you were enrolled on the date you changed employers. Otherwise, you will have to wait until the next annual enrollment. The time you worked for either employer counts toward your eligibility.

Certificates of Coverage from Insurance Carrier

The LTD insurance coverage is fully-insured under an insurance policy described in the *Plan Administration* section of this SPD. The LTD insurance benefits are described in the insurance carrier's Certificates of Coverage. The Certificates of Coverage summarize and explain the LTD insurance benefits, when coverage begins, when benefits begin and end, and coverage and benefit limitations and exclusions (including pre-existing condition exclusions) and are made a part of this SPD.

Classes of Employees

Class 1. (formerly Class 2 in the SPD for the 2021 Plan Year) The Certificate of Coverage booklet for "Class 1" describes the LTD coverage available to all active, full-time employees with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period), excluding employees described in Classes 5, 7, 7C, 8, 9 and 10 below.

Class 3. The Certificate of Coverage booklet for "Class 3" describes the LTD coverage available to all employees classified as part-time with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 24 hours per week (or 48 hours per pay period), excluding employees described in Class 4A or Class 9 below.

Class 4A. The Certificate of Coverage booklet for "Class 4A" describes the LTD coverage available to all active, employees classified as part-time Directors with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 24 hours per week (or 48 hours per pay period).

Class 5. The Certificate of Coverage booklet for "Class 5" describes the LTD coverage available to all active, full-time employees classified as Directors with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period).

Class 7. The Certificate of Coverage booklet for "Class 7" describes the LTD coverage available to all active, full-time employees classified as Vice President level and above, excluding members of the Senior Leadership Team, with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period).

Class 7C. The Certificate of Coverage booklet for "Class 7C" describes the LTD coverage available to all active, full-time employees classified as Vice President level and above who are members of the Senior Leadership Team, with six (6) or more months of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period).

Class 8. The Certificate of Coverage booklet for "Class 8" describes the LTD coverage available to all active, full-time Physician employees of Physician Groups, L.C., Fairview Heights Medical Group, S.C., Memorial Medical Group, LLC, or Missouri Baptist Hospital of Sullivan, with 30 or more days of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period).

Class 9. The Certificate of Coverage booklet for "Class 9" describes the LTD coverage available to all active, part-time Physician employees of Physician Groups, L.C., Fairview Heights Medical Group, S.C., Memorial Medical Group, LLC, or Missouri Baptist Hospital of Sullivan, with 30 or more days of Active Employment, regularly scheduled to work a minimum of 24 hours per week (or 48 hours per pay period).

Class 10. The Certificate of Coverage booklet for "Class 10" describes the LTD coverage available to all active, full-time Nurse Practitioner employees and full-time Physician Assistant employees of Physician Groups, L.C., Fairview Heights Medical Group, S.C., Memorial Medical Group, LLC, or Missouri Baptist Hospital of Sullivan, with 30 or more days of Active Employment, regularly scheduled to work a minimum of 35 hours per week (or 70 hours per pay period).

For purposes of the Classes listed herein, the term "regularly scheduled to work" has the meaning ascribed to "works" in the *Eligibility* section above.

NOTE: Please keep your applicable Certificate of Coverage with this SPD for a description of your LTD benefits.

When Coverage Ends

Your coverage will end on the earliest of the following dates:

- The last day of the month you cease to be Actively at Work unless (a) Active Work ceases during a temporary layoff or approved leave of absence, provided that coverage will not continue more than twelve (12) months from the date you stopped Active Work; or (b) Active Work ceases due to a Sickness or Injury and you are eligible for *Continuation of Coverage if You Are Disabled* as described below.

- The date you are no longer eligible for coverage.
- The date the Plan is terminated, the insurance contract ends, or a specific benefit terminates.
- The last day of the period for which you make any required contribution (you are not required to pay premiums while you are receiving LTD benefits).
- The last day of the month following the date you submit notice to drop coverage due to a qualified change in status event (see the *Changing Coverage* section), provided you do so within thirty-one (31) days of the change in status event date.
- The date you fail to comply with the terms and conditions of the Plan documents (which include, but are not limited to, this SPD, Certificates of Coverage, and the insurance policy).

Notwithstanding the above, your coverage may be continued during a leave of absence granted under the Family and Medical Leave Act of 1993 (FMLA) if premiums are paid.

Continuation of Coverage if You Are Disabled

If your coverage under this Plan ends because your employment ends, or you are no longer eligible, and you are Disabled, your coverage will be continued:

- During the 180-day Elimination Period (described in the applicable Certificate of Coverage), while you remain totally Disabled by the same Disability.
- After the 180-day Elimination Period, for as long as you are entitled to benefits under the Plan.

Coverage Costs

BJC provides LTD coverage (60% of base pay) at no cost to eligible full-time employees (thirty-five (35) hours per week/seventy (70) hours per pay period) after six (6) months of service in Classes 1, 5, 7, and 7C.

Eligible part-time employees (twenty-four (24) hours per week/forty-eight (48) hours per pay period) in Classes 3 and 4A pay the full premium with after-tax deductions. Therefore, any LTD benefits paid to part-time employees are not taxable.

BJC provides LTD Coverage at no cost to eligible employees in Classes 8, 9, and 10.

The Pre-Tax Advantage

If you are a full-time employee, you pay for many of your benefits, including LTD benefits, on a pre-tax basis (part-time employees pay for LTD coverage on an after-tax basis). This will affect how benefits are paid if you are unable to work due to a long-term disability. Please refer to the Coverage Costs section above. Paying premiums on a pre-tax basis means the cost of your contributions are taken from your pay before federal and state income taxes are deducted. This lowers your pay, which means you owe less in taxes. There are some important facts you should be aware of regarding this special tax break:

- In exchange for the tax break, the IRS generally requires that your annual benefit elections for pre-tax benefits will be locked in for the entire calendar year. There are exceptions to this rule if you have a qualifying status change during the year, as described in the section *Changing Coverage*, near the end of this SPD.
- Benefits that are based on the amount of your salary, such as your disability, life and accidental death and dismemberment insurance, are generally not affected by your pre-tax deductions. These benefits are based on your total, unreduced base pay.
- By federal law, you do not pay Social Security (FICA) taxes on the pre-tax money you set aside for benefits. You should be aware that this could mean reduced benefits when you become eligible for Social Security. This reduction is generally very small, however, and may be outweighed by your current tax savings.

Claims and Appeal Procedures - LTD

How to File a Claim

If you become disabled, and you are receiving Short-Term Disability benefits administered by Lincoln, your claim will be transitioned to LTD by your Lincoln claim manager, if applicable. You may also obtain instructions on How to Report an LTD claim from the BJC Total Rewards website. If you are not receiving STD benefits administered by Lincoln, you may report an LTD claim by calling Lincoln at 800-213-1580 or by completing an online claim at mylincolnportal.com. Claims should be reported within thirty (30) days of the date of the loss on which your LTD claim is based. Claims not filed within one (1) year after proof is otherwise required will be denied unless you are not legally competent.

Long-term disability benefits help provide a guaranteed level of income when combined with Social Security disability benefits. As a result, you must file a claim for LTD benefits and a claim with the Social Security Administration for Social Security disability benefits. Lincoln claim managers review each LTD claim for Social Security Disability Insurance potential and, if appropriate, will refer you to your Social Security Disability Insurance Advocacy partner who will assist you throughout the entire process from initial application through all appeal levels.

Here's how to apply for Social Security disability benefits on your own:

Step 1

Apply at your local Social Security office or apply online.

- You can call your local Social Security office or visit in person. The address and telephone number are in your local telephone directory. Or you can visit the Social Security Web site at www.socialsecurity.gov.
- Ask for a form to apply for disability benefits and for SSA Publication No. 05-10029, Disability Benefits. This booklet explains how to apply for Social Security benefits.
- If you are hospitalized or homebound, you can ask a Social Security representative to visit you in the hospital or at home. The representative will help you apply for benefits.

Being eligible for Social Security disability has many advantages:

- Your Social Security benefit when you retire will be larger.
- Here's why: Your Social Security retirement benefit is figured in part by taking the total amount of income you made and dividing it by the number of years you worked. The years you are eligible for Social Security disability benefits, however, do not count as years worked. Your potential benefit will be divided by a smaller number, resulting in a larger amount:

After two years of eligibility for Social Security disability benefits, you become eligible for Medicare insurance. In most cases, Social Security cost-of-living adjustments will not affect your LTD benefits.

Step 2

File an LTD claim.

Before you call Lincoln or go online, please have this information handy:

- Your name, address, phone number, birth date, Social Security number and email address.
- Employment information, such as date hired and job title.
- The reason for your claim – injury or sickness.
- A description of your injury or sickness, symptoms, and/or diagnosis.
- Include the date your symptoms started and if you've had these symptoms before.
- Workers' compensation claims you've filed or plan to file.
- Details about doctor, hospital, or clinic visits, including dates and contact information.

After reporting the LTD claim, Lincoln will send you a letter. It will include a form that gives Lincoln permission to get other information they may need to finish processing your claim. Sign and return that form. Also check with your doctor to see if there are any other forms you need to sign.

A disability case manager may call BJC for a list of your job requirements. The disability case manager will also call your doctor for your medical records. This information will help Lincoln figure out how long you may be out of work, and the benefits you may be able to receive.

If Lincoln needs more information, you will be asked for it. The claims process is very thorough and may take some time. By filling out the claim forms as soon as possible, you'll help make sure your benefit check will not be delayed. Once the claim is accepted, you will receive your first check, along with a letter explaining how your benefits were calculated.

As often as Lincoln may reasonably require, you must provide written proof of your continued disability and that you are being regularly attended by a doctor. In addition, Lincoln may require that you be examined by an independent doctor or other expert of its choice to determine the extent of any sickness or injury for which you have made a claim. More information about the Plan and your rights as a participant are included in the *ERISA Rights* section of this summary plan description.

Initial Claims Determinations

Lincoln will decide claims within a reasonable period of time, but not later than forty-five (45) days after a claim is received. This time period may be extended for an additional sixty (60) days, in the form of two 30-day extensions, when necessary due to matters beyond the control of the insurance company. You will be advised in writing of the need for an extension during the initial 45-day period and you will be notified of the need for a second extension of time before the end of the first extension period. The notice will specifically explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and any additional information needed to resolve those issues. If the extension is needed because you failed to submit information necessary to decide the claim, the notice will specifically describe the needed information and you will be allowed forty-five (45) days from receipt of the notice to provide the additional information. The timeframe for deciding the claim will be suspended from the date the notice of extension is sent until the date on which you respond to the notice. If you do not provide the requested information within the specified timeframe, your claim will be decided without that information.

If Lincoln denies your claim for a benefit in whole or in part, you will receive a written notice that will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of any additional material or information necessary to complete the claim and an explanation of why such material or information is necessary.
- A description of the steps you must follow (including applicable time limits) if you want to appeal the denial of your claim, including:
  - Your right to submit written comments and have them considered.
  - Your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
  - Your right to bring a civil action under Section 502 of ERISA if your claim is denied on appeal.
- Either the specific internal rules, guidelines, protocols, standards, or other similar criteria relied on in denying your claim or, alternatively a statement that such rules, guidelines, protocols, standards, or other similar criteria do not exist.
- If the denial was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request.
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration.

- A statement that you are entitled, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim. and
- Notice in a culturally and linguistically appropriate manner.

Review of Denied Claims (Appeals)

You must appeal any denial of your claim to Lincoln. This appeal must be made in writing within one hundred eighty (180) days after you receive the written notice that your claim has been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial.

Your written appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate. At your request, you will be provided, free of charge, with reasonable access to, and copies of, all documents, records, and other information relevant to the claim.

Lincoln will make a decision on your appeal within a reasonable period of time but no longer than forty-five (45) days after it is submitted. This time period may be extended for an additional forty-five (45) days if special circumstances make an extension necessary. You will be advised in writing of the need for an extension during the initial 45-day period and a determination will be made no more than ninety (90) days after the appeal was submitted. If the extension is needed because you failed to submit information necessary to decide the appeal, the period for deciding the appeal shall be tolled from the date on which the insurance company sends you notification of the extension until the date on which you respond to the request for additional information.

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination. The review will not give deference to the initial denial. In addition, the individual who decides your appeal will not be the same individual who decided your initial claim denial and will not be that individual's subordinate.

Lincoln may consult with a health professional in deciding your appeal, except that any health professional consulted in connection with your appeal will not have been involved in the original benefit determination or be a subordinate of the health professional who was involved.

Notice of Decision

You will be notified in writing if the decision on appeal upholds the initial denial of your claim.

Lincoln's notice of denial shall include:

- The specific reason or reasons for denial with reference to those Plan provisions on which the denial is based;
- A statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of all documents, records, and other information relevant to your claim;
- A statement describing any voluntary appeal procedures offered by Lincoln and your right to obtain the information about such procedures, and a statement of your right to bring an action under ERISA, including any applicable contractual limitations period that applies to your right to bring such an action and the calendar date on which the contractual limitations period expires;
- Either the specific internal rules, guidelines, protocols, standard or other similar criteria of the Plan relied upon in making the adverse decision or, alternatively, a statement that such rules, guidelines, protocols, standards, or other similar criteria of the Plan do not exist;
- If the adverse decision was based on a medical necessity, experimental treatment, or similar exclusion or limit, an explanation of the scientific or clinical judgment for the adverse decision, or a statement that such explanation will be provided free of charge upon request;
- If applicable, the reason for not following the views of the treating professional, medical or vocational experts, or a disability determination by the Social Security Administration; and
- Notice in a culturally and linguistically appropriate manner.

Lincoln's decision is final and binding on all individuals dealing with or claiming benefits under the Plan.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

Glossary of LTD Terms (See also LTD Definitions in Your Certificate of Coverage)

Active Employment, Active Service, or Actively at Work with your employer means that you report to work at your usual place of employment or any other business location where you are required to travel, and that you are able to perform the Material and Substantial Duties of your regular occupation for the normal workday. You will be considered to be actively at work on a day that is not one of your employer's scheduled work days only if you were actively at work on the preceding scheduled work day. You will be considered actively at work during an excused leave of absence or an emergency leave of absence (other than a medical leave for your own disabling condition and layoff) if you were actively at work on the preceding scheduled work day.

You must be working at least the minimum number of hours for your class of employment and your work site must be your employer's usual place of business; an alternative work site at the direction of your employer, including your home; or a location to which your job requires travel. Normal vacation is considered Active Employment.

Disabled or Disability has the meaning as defined in the applicable Certificate of Coverage from the insurance company.

Elimination Period means a period of continuous Disability which must be satisfied before you are eligible to receive benefits under the Plan.

Injury means any bodily impairment resulting directly from an accident and independently of all other causes.

Material and Substantial Duties has the meaning as defined in the applicable Certificate of Coverage from the insurance company.

Sickness means illness, disease, pregnancy, or complications of pregnancy.

OTHER BENEFITS

Legal Services Plan

Your BJC HealthCare Legal Services Plan is designed to provide you convenient access to quality legal services and protection from the high cost of legal fees. Your benefits provide an offering that pays for attorney fees in many of the different types of legal matters you may face. The Legal Services Plan provides you with access to a network of participating law firms from which you may seek legal assistance. Lawyers in this network are called "Participating Plan Attorneys." When you contact a Participating Plan Attorney, he or she will determine whether the legal services are covered by the Legal Services Plan.

Your Legal Services Plan provides flexible benefit levels that permit you to use your own attorney. Simply file for reimbursement up to your maximum benefits for fees paid to your attorney when legal work is complete. The covered legal services are described below. The actual provisions of the Legal Services Plan are set out in a written document maintained by BJC HealthCare. All statements made in this section of the SPD are subject to the provisions and terms of that document, which control in the event of conflict with this section of the SPD.

Effective January 1, 2020, the MetLife Legal Plan, administered by MetLife Legal Plans, is the Legal Services Plan provider.

If you have any questions, please contact MetLife Legal Plans' Client Service Center at 1-800-821-6400 Monday-Friday 7 a.m. to 7 p.m. CST.

Eligibility and Enrollment

Employee Eligibility

You are eligible to participate in the Legal Services Plan if you are classified in BJC HealthCare's payroll system as a regular full-time employee who works at least thirty-five (35) hours per week (seventy (70) hours per pay period), or as a regular part-time employee who works at least twenty-four (24) hours per week (forty-eight (48) hours per pay period), regardless of retroactive reclassification. For purposes of initial eligibility, the term "work" within this SPD means the budgeted hours in BJC's payroll system and not the hours actually worked.

Temporary, PRN and per diem employees are not eligible to participate in the Legal Services Plan.

In order to maintain and continue eligibility under the Legal Services Plan after your initial eligibility date, you must continue to actually work a minimum of: thirty-five (35) hours per week (seventy (70) hours per pay period) if you are a regular full-time employee, or twenty-four (24) hours per week (forty-eight (48) hours per pay period) if you are a regular part-time employee. BJC HealthCare reserves the right to conduct periodic audits of the actual hours regularly worked from BJC HealthCare's payroll system to ensure that employees are working the hours required to maintain benefit eligibility. BJC HealthCare reserves the right, based on the individual results of each employee's audit to update an employee's eligibility status based on those actual hours worked. For purposes of maintaining eligibility, hours actually worked include PTO, STD, low census, and unpaid approved leave hours.

Dependent Eligibility

Your dependents eligible for coverage under the Legal Services Plan include:

- Your spouse. For purposes of the Legal Services Plan described in this SPD, an individual will be treated as your "spouse" only if you and such individual are lawfully married (as determined under applicable law at the time and location where the marriage was performed). The marriage must be memorialized by a marriage certificate issued by an entity entrusted with the appropriate legal authority to recognize such marriage.
- Your child or children up to the age of 26.

- Your permanently and totally disabled unmarried child age 26 or older, provided the disability began before he or she reached the limiting age for coverage under the Legal Services Plan. A child is permanently and totally disabled if he or she is unable to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment that can be expected to result in death or that has lasted or can be expected to last for a continuous period of not less than twelve (12) months. You must provide proof of the disability within thirty-one (31) days after the date your child reaches the limiting age of 26 (your child must be covered under the Plan when he or she reaches the limiting age) and as requested by the Benefits Manager. The child is not required to have the same principal place of abode as you. However, if the child does not have the same principal place of abode as you, he or she must receive over one-half of his or her support from you.

For purposes of the Legal Services Plan, "child" means:

- The employee's natural child, step-child, legally adopted child or a child placed with the employee for adoption.
- Any other child (including a grandchild) who has been placed with the employee by an authorized placement agency or by judgment, decree, or other order of any court of competent jurisdiction.

You may add the Plus Parents buy up option to your enrollment, and your parents and parents-in-law will be eligible for certain legal services under the Legal Service Plan.

Enrollment Process

You must complete your enrollment for you and your dependent(s) no later than thirty-one (31) days after your hire date for a new hire. For this purpose, "hire date" means the date you are first classified as an employee in the payroll system. If you experience a qualified change in status event as indicated in the *Changing Coverage* section of this SPD, you must complete your enrollment for you and your dependent(s) no later than thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption).

NOTE: If an election is not made in a timely manner, it will be assumed that you do not wish to elect coverage and you and your eligible dependents will not be enrolled in the Legal Services Plan.

Annual Enrollment

If you do not take affirmative action during annual enrollment you will be deemed to have elected to enroll or not enroll based on your election for the prior year.

When Coverage Begins

For new hires, your coverage will be effective on the first day of the month following your hire date, provided that you have timely enrolled.

If you experience a qualified change in status event during the Plan year, your coverage will be effective on the first day of the month on or after the date of your change in status event, provided you have timely enrolled you and your dependent(s). You must enroll no later than thirty-one (31) days after your change in status event date (sixty (60) days if the event is your child's birth, adoption, or placement for adoption). You will not be permitted to change your coverage until the next annual enrollment period for the subsequent Plan year.

When Coverage Ends

Your coverage will end on the earliest of the following:

- The date the Legal Services Plan is terminated, the agreement with MetLife Legal Plans is terminated, or a specific benefit terminates;
- The last day of the Plan year if you choose not to reenroll for the next Plan year;
- The date you are no longer an eligible employee; or
- The last day of the period for which your final premium is paid, subject to the statutory grace period.

Portability

You may continue this insurance by electing the option of portability when you no longer qualify as an eligible employee. You must apply for portability within sixty (60) days of this disqualifying event and make arrangements for premium payment. Portability coverage will take effect, subject to payment of the initial premium, as of the date your coverage under the group policy terminates. To apply, contact MetLife Legal Plans at 800-821-6400.

Obtaining Legal Services

Client Service Center

You may also use the MetLife Legal Plan by calling MetLife Legal Plans' Client Service Center at 1-800-821-6400 Monday – Friday 7 a.m. to 7 p.m., Central Time. Be prepared to give your Membership Number and Zip Code. If you are a spouse or an eligible dependent child of an eligible person, or a parent or parent-in-law under the Plus Parent buy up option, you will need the Membership Number and Zip Code of the employee through whom you are eligible. The Client Service Representative who answers your call will:

- Verify your eligibility for services;
- Make an initial determination of whether and to what extent your case is covered (the Participating Plan Attorney will make the final determination of coverage);
- Give you a Case Number which is similar to a claim number (you will need a new Case Number for each new case you have);
- Give you the telephone number of the Participating Plan Attorney most convenient to you; and
- Answer any questions you have about the Legal Services Plan.

You then call the Participating Plan Attorney to schedule an appointment at a time convenient to you. Evening and Saturday appointments are available.

If you choose, you may select your own attorney. Also, where there are no Participating Plan Attorneys, you will be asked to select your own attorney. In both of these circumstances, MetLife Legal Plans will reimburse you for these non-Participating Plan Attorneys' fees in accordance with a set fee schedule.

For services to be covered, you or your eligible dependents, or parent or parent-in law under the Plus Parents buy up option, must have obtained a Case Number, retained an attorney and the attorney must begin work on the covered legal matter while you are an eligible member of the Legal Services Plan.

Website

To use the MetLife Legal Plan, visit legalplans.com and create an account with the email of your choice, personal or work, and password to begin setting up your account. Once you do this, you will be asked to provide some personal information, including your full name, address and the employer or organization offering the legal plan to confirm your eligibility.

Once your eligibility is confirmed, you will have access to a guided process to see your coverages and be connected to an attorney to help you with your legal issue as needed.

The website’s main menu allows you to choose from the type of legal services you need help with:

- Family Law
- Wills & Estates
- Debt Matters
- Real Estate
- Traffic & Criminal
- Injury & Insurance

For example, the website provides you with the ability to create wills, living wills and powers of attorney online in as little as 15 minutes. The self-guided process allows you to create state-specific documents for yourself and your spouse.

To access this service, click on “Wills and Estates” from the main menu, and then click on “Estate Plan Bundle” from the coverage page.

What Services are Covered

The MetLife Legal Plan entitles you and your eligible dependents, or parent or parent-in-law under the Plus Parents buy up option, to receive certain personal legal services. The available benefits are very comprehensive, but there are limitations and other conditions, which must be met. Please take time for yourself and your family to read the description of benefits carefully.

All benefits are available to you and your spouse and dependents, unless otherwise noted.

See Appendix A for benefits available to you and your spouse and dependents.

See Appendix B for benefits available under the Plus Parents buy up option.

Appendix A - Definition of Covered Services

Advice and Consultation

Office Consultation

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Participating Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Participating Plan Attorney will identify any further coverage available under the Legal Services Plan, and will undertake representation if the Participant so requests. If representation is covered by the Legal Services Plan, the Participant will not be charged for the Participating Plan Attorney's services. If representation is recommended, but is not covered by the Legal Services Plan, the Participating Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Participating Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Participating Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation.

Telephone Advice

This service provides the opportunity to discuss with an attorney any personal legal problems that are not specifically excluded. The Participating Plan Attorney will explain the Participant's rights, point out his or her options and recommend a course of action. The Participating Plan Attorney will identify any further coverage available under the Legal Services Plan, and will undertake representation if the Participant so requests. If representation is covered by the Legal Services Plan, the Participant will not be charged for the Participating Plan Attorney's services. If representation is recommended, but is not covered by the Legal Services Plan, the Participating Plan Attorney will provide a written fee statement in advance. The Participant may choose whether to retain the Participating Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year a Participant may use this service; however, for a non-covered matter, this service is not intended to provide the Participant with continuing access to a Participating Plan Attorney in order to seek advice that would allow the Participant to undertake his or her own representation

Consumer Protection

Consumer Protection Matters

This service covers the Participant as a plaintiff, for representation, including trial, in disputes over consumer goods and services where the amount being contested exceeds the small claims court limit in that jurisdiction and is documented in writing. This service does not include disputes over real estate, construction, insurance, or collection activities after a judgment.

Small Claims Assistance

This service covers counseling the Participant on prosecuting a small claims action; helping the Participant prepare documents; advising the Participant on evidence, documentation, and witnesses; and preparing the Participant for trial. The service does not include the Participating Plan Attorney's attendance or representation at the small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Personal Property Protection

This service covers counseling the Participant over the phone or in the office on any personal property issue such as consumer credit reports, contracts for the purchase of personal property, consumer credit agreements or installment sales agreements. Counseling on pursuing or defending small claims actions is also included. The service also includes reviewing any personal legal documents and preparing promissory notes, affidavits, and demand letters.

Debt Matters

Debt Collection Defense

This benefit provides Participants with an attorney's services for negotiation with creditors for a repayment schedule and to limit creditor harassment, and representation in defense of any action for personal debt collection, tax agency debt collection, foreclosure, repossession, or garnishment, up to and including trial if necessary. It includes a motion to vacate a default judgment. It does not include counter, cross- or third-party claims; bankruptcy; any action arising out of family law matters including support and post decree issues; or any matter where the creditor is affiliated with the sponsor or employer.

Identity Management Services

This service provides the Participant with access to LifeStages Identity Management Services provided by CyberScout, LLC, formerly known as IDT911, LLC. CyberScout is not a corporate affiliate of MetLife Legal Plans. These services include both Proactive Services when the Participant believes their personal data has been compromised as well as Resolution Services to assist the Participant in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery and Replacement services are covered by this service.

Identity Theft Defense

This service provides the Participant with consultations with an attorney regarding potential creditor actions resulting from identity theft and attorney services as needed to contact creditors, credit bureaus and financial institutions. It also provides defense services for specific creditor actions over disputed accounts. The defense services include limiting creditor harassment and representation in defense of any action that arises out of the identity theft such as foreclosure, repossession, or garnishment, up to and including trial if necessary. The service also provides the Participant with online help and information about identity theft and prevention. It does not include counter claims, cross claims, bankruptcy, any action arising out of divorce or post decree matters, or any matter where the creditor is affiliated with the sponsor or employer.

Personal Bankruptcy or Wage Earner Plan

This service covers the Employee and spouse in pre-bankruptcy planning, the preparation and filing of a personal bankruptcy or Wage Earner petition, and representation at all court hearings and trials. This service is not available if a creditor is affiliated with the Employer, even if the Employee or spouse chooses to reaffirm that specific debt.

Tax Audits

This service covers reviewing tax returns and answering questions the IRS, or a state or local taxing authority has concerning the Participant's tax return; negotiating with the agency; advising the Participant on necessary documentation; and attending an IRS or a state or local taxing authority audit. The service does not include prosecuting a claim for the return of overpaid taxes or the preparation of any tax returns.

Defense of Civil Lawsuits

Administrative Hearing Representation

This service covers the Participant in defense of civil proceedings before a municipal, county, state or federal administrative board, agency, or commission. It includes the hearing before an administrative board or agency over an adverse governmental action. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters or litigation of a job-related incident.

Civil Litigation Defense

This service covers the Participant in defense of an arbitration proceeding or civil proceeding before a municipal, county, state or federal administrative board, agency, or commission, or in a trial court of general jurisdiction. It does not apply where services are available or are being provided by virtue of an insurance policy. It does not include family law matters, post judgment matters, matters with criminal penalties or litigation of a job-related incident. Services do not include bringing counterclaims, third party or cross claims.

Incompetency Defense

This service covers the Participant in the defense of any incompetency action, including court hearings when there is a proceeding to find the Participant incompetent.

Document Preparation

Affidavits

This service covers the preparation of any affidavit in which the Participant is the person making the statement.

Deeds

This service covers the preparation of any deed for which the Participant is either the grantor or grantee.

Demand Letters

This service covers the preparation of letters that demand money, property, or some other property interest of the Participant, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Participant. Negotiations and representation in litigation are not included.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the Participant is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes

This service covers the preparation of any promissory note for which the Participant is the payor or payee.

Document Review

This service covers the review of any personal legal document of the Participant, such as letters, leases, or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing

deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Family Law

Name Change

This service covers the Participant for all necessary pleadings and court hearings for a legal name change.

Prenuptial Agreement

This service covers representation of the Employee and includes the negotiation, preparation, review and execution of a Prenuptial Agreement between the Employee and his or her fiancé/partner prior to their marriage or legal union (where allowed by law), outlining how property is to be divided in the event of separation, divorce or death of a spouse. Representation is provided only to the Employee. The fiancé/partner must have separate counsel or must waive his or her right to representation. It does not include subsequent litigation arising out of a Prenuptial Agreement.

Protection from Domestic Violence

This service covers the Employee only, not the spouse or dependents, as the victim of domestic violence. It provides the Employee with representation to obtain a protective order, including all required paperwork and attendance at all court appearances. The service does not include representation in suits for damages, defense of any action, or representation for the offender.

Divorce, Dissolution and Annulment (Contested and Uncontested)

This service is available to Employees only, not to spouses or dependents. This service includes preparing and filing all necessary pleadings, motions, and affidavits, drafting settlement or separation agreements, and representation at the hearing or trial, whether the Employee is a plaintiff or a defendant. This service does not include disputes that arise after a decree is issued.

Adoption and Legitimization (Contested and Uncontested)

This service covers all legal services and court work in a state or federal court for an adoption for the Employee and spouse. Legitimization of a child for the Employee and spouse, including reformation of a birth certificate, is also covered.

Guardianship or Conservatorship (Contested or Uncontested)

This service covers establishing a guardianship or conservatorship over a person and his or her estate when the Employee or spouse is appointed as guardian or conservator. It includes obtaining a permanent and/or temporary guardianship or conservatorship, gathering any necessary medical evidence, preparing the paperwork, attending the hearing, and preparing the initial accounting. This service does not include representation of the person over whom guardianship or conservatorship is sought, or any annual accountings after the initial accounting or terminating the guardianship or conservatorship once it has been established.

Immigration

Immigration Assistance

This service covers advice and consultation, preparation of affidavits and powers of attorney, review of any immigration documents and helping the Participant prepare for hearings.

Insurance Matters

Insurance Claims

This service provides the Participant with assistance in making insurance claims with the Participant's own carrier, provided the carrier is not affiliated with the Employee's Sponsor or Employer. Litigation of coverage issues is included. Litigation of damages is not included.

Personal Injury

Personal Injury (25% Network Maximum)

Subject to applicable law and court rules, Participating Plan Attorneys will handle personal injury matters (where the Participant is the plaintiff) at a maximum fee of 25% of the gross award. It is the Participant's responsibility to pay this fee and all costs.

Real Estate Matters

Boundary or Title Disputes (Primary Residence)

This service covers negotiations and litigation arising from boundary or real property title disputes involving a Participant's primary residence, where coverage is not available under the Participant's homeowner or title insurance policies. The service includes filing to remove a mechanic's lien.

Eviction and Tenant Problems (Primary Residence – Tenant Only)

This service covers the Participant as a tenant for matters involving leases, security deposits or disputes with a residential landlord. The service includes eviction defense, up to and including trial. It does not include representation in disputes with other tenants or as a plaintiff in a lawsuit against the landlord, including an action for return of a security deposit.

Security Deposit Assistance (Primary Residence – Tenant Only)

This service covers counseling the Participant as a tenant in recovering a security deposit from the Participant's residential landlord for the Participant's primary residence; reviewing the lease and other relevant documents; and preparing a demand letter to the landlord for the return of the deposit. It also covers assisting the Participant in prosecuting a small claims action; helping prepare documents; advising on evidence, documentation and witnesses; and preparing the Participant for the small claims trial. The service does not include the Participating Plan Attorney's attendance or representation at small claims trial, collection activities after a judgment or any services relating to post-judgment actions.

Home Equity Loans (Primary Residence)

This service covers the review or preparation of a home equity loan on the Participant's primary residence.

Home Equity Loans (Second or Vacation Home)

This service covers the review or preparation of a home equity loan on the Participant's second or vacation home.

Property Tax Assessment (Primary Residence)

This service covers the Participant for review and advice on a property tax assessment on the Participant's primary residence. It also includes filing the paperwork; gathering the evidence; negotiating a settlement; and attending the hearing necessary to seek a reduction of the assessment.

Refinancing of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's primary residence. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment, or income purpose.

Refinancing of Home (Second or Vacation Home)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the refinance agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the refinancing of or obtaining a home equity loan on a Participant's second home or vacation home. The benefit also includes attendance of an attorney at closing. This benefit includes obtaining a permanent mortgage on a newly constructed home. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the refinancing of a second home, vacation property or property that is held for any rental, business, investment, or income purpose.

Sale or Purchase of Home (Primary Residence)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's primary residence or of a vacant property to be used for building a primary residence. The benefit also includes attendance of an attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home, vacation property, rental property, property held for business or investment or leases with an option to buy.

Sale or Purchase of Home (Second or Vacation Home)

This service covers the review or preparation, by an attorney representing the Participant, of all relevant documents (including the construction documents for a new second home or vacation home, the purchase agreement, mortgage and deed, and documents pertaining to title, insurance, recordation and taxation), which are involved in the purchase or sale of a Participant's second home or vacation home or of a vacant property to be used for building a second home or vacation home. The benefit also includes attendance of a Participating Plan Attorney at closing. It does not include services provided by any attorney representing a lending institution or title company. The benefit does not include the sale or purchase of a second home or vacation home held for rental purpose, business, investment or income or leases with an option to buy.

Zoning Applications

This service provides the Participant with the services of a lawyer to help get a zoning change or variance for the Participant's primary residence. Services include reviewing the law, reviewing the surveys, advising the Participant, preparing applications, and preparing for and attending the hearing to change zoning.

Traffic and Criminal Matters

Juvenile Court Defense

This service covers the defense of a Participant and a Participant's dependent child in any juvenile court matter, provided there is no conflict of interest between the Participant and the dependent child. When a conflict exists, or where the court requires separate counsel for the child, this service provides an attorney for the Employee only, including services for Parental Responsibility.

Traffic Ticket Defense (No DUI)

This service covers representation of the Participant in defense of any traffic ticket including traffic misdemeanor offenses, except driving under influence or vehicular homicide, including court hearings, negotiation with the prosecutor and trial.

Restoration of Driving Privileges

This service covers the Participant with representation in proceedings to restore the Participant's driving license.

Wills and Estate Planning

Trusts

This service covers the preparation of revocable and irrevocable living trusts for the Participant. It does not include tax planning or services associated with funding the trust after it is created.

Living Wills

This service covers the preparation of a living will for the Participant.

Powers of Attorney

This service covers the preparation of any power of attorney when the Participant is granting the power.

Probate Proceedings

This service provides representation for the Employee or spouse when the Employee or spouse is probating an estate and has been appointed executor or administrator. The service includes all of the court proceedings to transfer probate assets from the decedent to the heirs; the correspondence necessary to transfer non-probate assets such as proceeds from insurance policies, joint bank accounts, stock accounts or a house; and any tax filings. This service does not include prosecuting or defending any litigation including a will contest.

Wills and Codicils

This service covers the preparation of a simple or complex will for the Participant. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Appendix B (Plus Parents buy up option)

Advice and Consultation

This service provides the opportunity to discuss with a Participating Plan Attorney any personal legal problems that are not specifically excluded. The Participating Plan Attorney will explain the Parent's rights, point out his or her options and recommend a course of action. The Participating Plan Attorney will identify any further coverage available under the Legal Services Plan, and will undertake representation if the Parent so requests. If representation is covered by the Legal Services Plan, the Parent will not be charged for the Participating Plan Attorney's services. If representation is recommended, but is not covered by the Legal Services Plan, the Participating Plan Attorney will provide a written fee statement in advance. The Parent may choose whether to retain the Participating Plan Attorney at his or her own expense, seek outside counsel, or do nothing. There are no restrictions on the number of times per year Parent may use this service; however, for a non-covered matter, this service is not intended to provide the Parent with continuing access to a Participating Plan Attorney in order to seek advice that would allow the Parent to undertake his or her own representation.

Debt Matters

Identity Management Services

This service provides the Parent with access to LifeStages Identity Management Services provided by CyberScout, formerly known as IDT911, LLC. These services include both Proactive Services when the Parent believes their personal data has been compromised as well as Resolution Services to assist the Parent in recovering from account takeover or identity theft with unlimited assistance to fix issues, handle notifications, and provide victims with credit and fraud monitoring. Theft Support, Fraud Support, Recovery and Replacement services are covered by this service.

Document Preparation

Affidavits

This service covers preparation of any affidavit in which the Parent is the person making the statement.

Demand Letters

This service covers the preparation of letters that demand money, property, or some other property interest of the Parent, except an interest that is an excluded service. It also covers mailing them to the addressee and forwarding and explaining any response to the Parent. Negotiations and representation in litigation are not included.

Document Review

This service covers the review of any personal legal document of the Parent, such as letters, leases, or purchase agreements.

Elder Law Matters

This service covers counseling the Participant over the phone or in the office on any personal issues relating to the Participant's parents as they affect the Participant. The service includes reviewing documents of the parents to advise the Participant on the effect on the Participant. The documents include Medicare or Medicaid materials, prescription plans, leases, nursing home agreements, powers of attorney, living wills and wills. The service also includes preparing deeds involving the parents when the Participant is either the grantor or grantee; and preparing promissory notes involving the parents when the Participant is the payor or payee.

Real Estate Matters

Deeds

This service covers the preparation of any deed for which the Parent is either the grantor or grantee.

Mortgages

This service covers the preparation of any mortgage or deed of trust for which the Parent is the mortgagor. This service does not include documents pertaining to business, commercial or rental property.

Promissory Notes

This service covers the preparation of any promissory note for which the Parent is the payor or payee.

Wills and Estate Planning

Living Wills

This service covers the preparation of a living will for the Parent.

Powers of Attorney

This service covers the preparation of any power of attorney when the Parent is granting the power.

Wills and Codicils

This service covers the preparation of a simple or complex will for the Parent. The creation of any testamentary trust is covered. The benefit includes the preparation of codicils and will amendments. It does not include tax planning.

Exclusions

Excluded services are those legal services that are not provided under the Legal Services Plan. No services, not even a consultation, can be provided for the following matters:

- Employment-related matters, including company or statutory benefits
- Matters involving the Employer, MetLife® and affiliates, and Participating Plan Attorneys
- Matters in which there is a conflict of interest between the employee and spouse or dependents or Parent in which case services are excluded for the spouse and dependents and Parent
- Appeals and class actions
- Farm, business or investment matters, and matters involving property held for investment or rental or issues when the Participant or Parent is the landlord
- Patent, trademark, and copyright matters
- Costs or fines
- Frivolous or unethical matters
- Matters for which an attorney-client relationship exists prior to the Participant or Parent becoming eligible for plan benefits

Glossary of Legal Services Terms

Covered Family Member

The Employee's eligible dependents as described above under Eligible Dependents.

Healthcare Coverage

Any policy for healthcare that an Employee and/or Covered Family Member has in effect over which some type of coverage, benefits, or privacy dispute arising while that policy is in effect as defined by the terms of that policy. Nothing in this Policy will pay or create any obligation to pay any healthcare benefits to any person for any reason, and any coverage related to this definition in this Legal Expense Policy must be related to an Employee's and/or Covered Family Member's dispute under a healthcare coverage policy.

Amendment or Termination

While BJC expects to continue the Legal Services Plan described herein, it reserves the right to amend or terminate the Legal Services Plan, in whole or in part, at any time. If the Legal Services Plan is terminated, all covered services then in process will be handled to their conclusion under the Legal Services Plan.

Administration and Funding

The Legal Service Plan is provided for and administered through a contract with MetLife Legal Plans, Inc. MetLife Legal Plans makes all determinations regarding attorneys' fees and what constitutes covered services. All contributions collected from employees electing this coverage are paid to MetLife Legal Plans, Inc.

Cost of the Plan

You pay the cost of the Legal Services Plan through after-tax payroll deductions, based on your enrollment choice.

Plan Confidentiality, Ethics, and Independent Judgment

Your use of the Legal Services Plan and the legal services is confidential. The Participating Plan Attorney will maintain strict confidentiality of the traditional lawyer-client relationship. Your employer will know nothing about your legal problems or the services you use under the Legal Services Plan. Plan administrators will have access only to limited statistical information needed for orderly administration of the Legal Services Plan.

No one will interfere with your Participating Plan Attorney's independent exercise of professional judgment when representing you. All attorneys' services provided under the Legal Services Plan are subject to ethical rules established by the courts for lawyers. The Participating Plan Attorney will adhere to the rules of the Legal Services Plan and he or she will not receive any further instructions, direction, or interference from anyone else connected with the Legal Services Plan. The attorney's obligations are exclusively to you. The attorney's relationship is exclusively with you. MetLife Legal Plans, Inc., or the law firm providing services under the Legal Services Plan is responsible for all services provided by their attorneys.

You should understand that the Legal Services Plan has no liability for the conduct of any Participating Plan Attorney. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Services Plan. You have the right to retain at your own expense any attorney authorized to practice law in this state.

Participating Plan Attorneys will refuse to provide services if the matter is clearly without merit, frivolous or for the purpose of harassing another person. If you have a complaint about the legal services you have received or the conduct of an attorney, call MetLife Legal Plans at 1-800-821-6400. Your complaint will be reviewed, and you will receive a response within two business days of your call.

You have the right to retain at your own expense any attorney authorized to practice law in the state. You have the right to file a complaint with the state bar concerning attorney conduct pursuant to the Legal Services Plan.

Other Special Rules

In addition to the coverages and exclusions listed, there are certain rules for special situations. Please read this section carefully.

What if other coverage is available to you? If you are entitled to receive legal representation provided by any other organization such as an insurance company or a government agency, or if you are entitled to legal services under any other legal plan, coverage will not be provided under this Legal Services Plan. However, if you are eligible for legal aid or Public Defender services, you will still be eligible for benefits under this Legal Services Plan, so long as you meet the eligibility requirements.

What if you are involved in a legal dispute with your dependents? You may need legal help with a problem involving your spouse or your children. In some cases, both you and your child may need an attorney. If it would be improper for one attorney to represent both you and your dependent, only you will be entitled to representation by the Participating Plan Attorney. Your dependent will not be covered under the Legal Services Plan.

What if you are involved in a legal dispute with your parent or parent-in law and you have Plus Parents coverage? This same exclusion as above, applies to a legal problem involving a parent or parent-in-law under the Plus Parents buyup option.

What if you are involved in a legal dispute with another employee? If you or your dependents are involved in a dispute with another eligible employee or that employee's dependents, MetLife Legal Plans will arrange for legal representation with independent and separate counsel for both parties.

What if the court awards attorneys' fees as part of a settlement? If you are awarded attorneys' fees as a part of a court settlement, the Legal Services Plan must be repaid from this award to the extent that it paid the fee for your attorney.

Denials of Benefits and Appeal Procedures

Denials of Eligibility

MetLife verifies eligibility using information provided by BJC HealthCare. When you call for services, you will be advised if you are ineligible and MetLife Legal Plans will contact BJC HealthCare for assistance. If you are not satisfied with the final determination of eligibility, you have the right to a formal review and appeal. Send a letter within 60 days explaining why you believe you are eligible to:

BJC HealthCare
Attn: Health & Welfare Benefits Dept / Plan Administrator
8300 Eager Rd., Suite 300C
St. Louis, MO 63144

Within 30 days, you will be provided with a written explanation.

The Plan Administrator will review your claim and respond to you with a determination. The decision of the Plan Administrator is final and binding.

Denials of Coverage

If you are denied coverage by MetLife Legal Plans or by any Participating Plan Attorney, you may appeal by sending a letter to:

MetLife Legal Plans, Inc.
Director of Administration
1111 Superior Avenue E, Suite 800
Cleveland, Ohio 44114-2507

The Director will issue MetLife Legal Plans' final determination within 60 days of receiving your letter. This determination will include the reasons for the denial with reference to the specific Legal Services Plan provisions on which the denial is based and a description of any additional information that might cause MetLife Legal Plans to reconsider the decision, an explanation of the review procedure and notice of the right to bring a civil action under Section 502(a) of ERISA.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court until the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary, or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant have exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

If you are having any concerns about this Legal Services Plan, please call MetLife Legal Plans at 1-800-821-6400. A MetLife Legal Plans' representative will help you resolve the issue.

Business Travel Accident (BTA)

Business travel accident (BTA) insurance provides extra protection if you die or sustain certain types of injuries in an accident while you are traveling on business authorized by your employer. Your employer provides this coverage at no cost to all regular employees that fall within one (1) of the classes noted in the *Eligibility* section below.

For business travel, a business trip is considered to commence when you leave your residence or regular place of employment or another place, whichever occurs last. The trip ends when you return to your residence or your regular place of employment, whichever occurs first, or you make a personal deviation. For purposes hereof, "personal deviation" means an activity that is not reasonably related to your business and not incidental to the business trip.

Business travel accident insurance does not cover commuting between your home and your place of employment, while on your employer's premises, or during personal deviations.

The BTA insurance is provided by Life Insurance Company of North America (Cigna).

Eligibility

Your employer provides BTA coverage at no cost to regular employees that fall within one (1) of the classes below:

Class	Description of Eligible Class
1	All active full-time employees of a participating employer classified as Chief Executive Officer or Executive Leadership
2	All active employees who are, or who are acting in the capacity of, emergency medical transport personnel of a participating employer
3	All active employees of a participating employer classified as Health Service Organization President, Vice President or Director and above (excluding those covered in classes 1 and 2)
4	All other active employees of a participating employer (excluding those covered in classes 1, 2 and 3)

When Coverage Ends

Your business travel coverage will end on the earliest of the following dates:

- The date you stop actively working or otherwise cease to be an eligible employee or cease to be in an eligible class. Your coverage will be reinstated on the day you return to work following an approved leave of absence.
- The date on which the Plan ends, or the insurance contract is terminated.

BTA Benefits Paid by the Plan

If bodily injuries result in any of the following losses, within one (1) year of a covered accident, the Plan will pay a benefit amount according to the following table:

COVERED LOSS	Benefit
Loss of Life	100% of the Principal Sum
Loss of Two or More Hands or Feet	100% of the Principal Sum
Loss of Sight of Both Eyes	100% of the Principal Sum
Loss of One Hand or One Foot and Sight in One Eye	100% of the Principal Sum
Loss of Speech and Hearing (both ears)	100% of the Principal Sum
Quadriplegia (total paralysis of both upper and lower limbs)	100% of the Principal Sum
Paraplegia (total paralysis of both lower limbs)	75% of the Principal Sum
Hemiplegia (total paralysis of upper and lower limbs on one side of the body)	50% of the Principal Sum
Uniplegia (total paralysis of one upper or one lower limb)	25% of the Principal Sum
Coma Monthly Benefit Number of Monthly Benefits When Payable Lump Sum Benefit When Payable	 1% of the Principal Sum 11 At the end of each month during which you remain comatose; 100% of the Principal Sum Beginning of the 12th month

COVERED LOSS	Benefit
Loss of One Hand or Foot	50% of the Principal Sum
Loss of Sight in One Eye	50% of the Principal Sum
Loss of Speech	50% of the Principal Sum
Loss of Hearing (in both ears)	50% of the Principal Sum
Severance and Reattachment of One Hand or Foot	50% of the Principal Sum
Loss of Thumb and Index finger of the same hand	25% of the Principal Sum
Loss of all Four Fingers of the Same Hand	25% of the Principal Sum
Loss of all the Toes of the Same Foot	20% of the Principal Sum

BTA Definitions

- "Loss of a Hand or Foot" means complete Severance through or above the wrist or ankle joint.
- "Loss of Sight" means the total, permanent loss of sight of one eye. The loss of sight must be irrecoverable by natural, surgical, or artificial means.
- "Loss of Speech" means total and permanent loss of audible communication which is by natural, surgical, or artificial means.
- "Loss of Hearing" means total and permanent loss of ability to hear any sound in both ears which by natural, surgical, or artificial means.
- "Loss of a Thumb and Index Finger of the Same Hand" or "Loss of Four Fingers of the Same Hand" means complete Severance through or above the metacarpophalangeal joints of the same hand (the joints between the fingers and the hand).
- "Loss of Toes" means complete Severance through the metatarsalphalangeal joint.
- "Paralysis" or "Paralyzed" means total loss of use. A Physician must determine the loss of use to be complete and not reversible at the time the claim is submitted.
- "Quadriplegia" means total Paralysis of both upper and lower limbs.
- "Hemiplegia" means total Paralysis of the upper and lower limbs on one side of the body.
- "Paraplegia" means total Paralysis of both lower limbs or both upper limbs.
- "Uniplegia" means total Paralysis of one upper or one lower limb.
- "Coma" means a profound state of unconsciousness from which the Covered Person is not likely to be aroused through powerful stimulation. The Coma must begin within thirty (30) days of the Covered Accident, continue for sixty (60) consecutive days and must be diagnosed and treated regularly by a Physician. Coma does not mean any state of unconsciousness intentionally induced during the course of treatment of a Covered Injury unless the state of unconsciousness results from the administration of anesthesia in preparation for surgical treatment of injuries sustained in that Covered Accident.
- "Severance" means complete separation and dismemberment of the part from the body.

Only one amount, the largest, will be paid for all losses resulting from an accident. This amount will not exceed the full coverage amount shown in the Amount of BTA Coverage section.

If more than one covered employee is injured or dies in the same accident, the Plan will not pay more than a total of $5 million for any one accident.

For purposes of this benefit, an "accident" means a sudden, unexpected, unusual, specific, and abrupt event that occurs by chance at an identifiable time and place while you are covered by the Plan.

Exposure and Disappearance

The policy covers claims for losses caused by exposure to the elements as the result of a covered accident after the forced landing, stranding, sinking, or wrecking of a vehicle in which you are traveling on business for your employer. Also, if you are not found within one year of the accident after the disappearance, sinking or wrecking of the vehicle in which you were riding at the time the covered accident occurred, you will be presumed to have died and a benefit may be paid to your beneficiary. However, if you are later found to be alive, the amount paid must be refunded by the person or persons to whom it was paid.

Amount of BTA Coverage

The benefit, also referred to as the Principal Sum in the above table, is $300,000 for officers, $250,000 for emergency medical transport personnel, $200,000 for department heads and above, and $75,000 for all other employees. If you work past age 70, your business travel insurance amount will be reduced at certain ages according to this table:

AGE AT DATE OF LOSS	APPLICABLE COVERAGE AMOUNT
Age 69 or younger	100%
70-74	65%
75-79	45%
80-84	30%
85 and older	15%

Naming a Beneficiary

Business travel accident death benefits will be paid to the same person you have designated as your beneficiary for your other life insurance benefits. If your beneficiary is not living at the time you die, or you do not name a beneficiary, your benefit will be paid in the following order:

- To your spouse, if living.
- If you have no living spouse, to your surviving children (in equal shares).
- If you have no living children, to your parents (in equal shares).
- If you have no living parent, to your siblings (in equal shares).
- If you have no living siblings, to your estate.

Instead of a lump sum payment, the insurance company may have installment payment options available.

All other benefits will be paid to you, if living, or to your beneficiary or your estate.

BTA Exclusions

The Plan does not pay benefits for loss caused by or resulting from:

- Suicide or attempted suicide while sane or intentionally self-inflicted injury.
- A war or act of war declared or undeclared.
- Taking part in a felony.
- Serving as a pilot or crew member of any aircraft. Crew member does not include active employees who are acting in the capacity of emergency medical transport personnel.
- Riding in an aircraft without a valid certificate of airworthiness or flown by a pilot without a valid license.
- Travel in an aircraft being used for crop dusting, spraying, or seeding; firefighting, sky writing, sky diving or hang gliding; pipeline or power line inspection; aerial photography or exploration; racing, endurance tests, stunt or acrobatic flying; or any operation which requires a special permit from the FAA, even if it is granted (this does not apply if the permit is required only because of the territory flown over or landed on).
- Sickness, illness, disease, bodily infirmity or medical or surgical treatment thereof, or viral infection, regardless of how contracted.
- Any bacterial infection that was not caused by an accidental cut, wound or food poisoning.
- Injury while a covered person is on full-time active duty in any armed forces.
- Voluntary self-administration of any drug or chemical substance.

Claims Procedures for Business Travel Accident Insurance

Filing a Claim

The insurance company must receive written notice of claim within thirty (30) days after your loss occurs or begins. The notice must include your name and the policy number. Please contact the BJC Benefits department for information on filing the claim notice. Within fifteen (15) days of receiving this notice, the insurance company will send claim forms to you. You must provide proof of claim within ninety (90) days after a covered loss occurred. If you cannot meet these time limits for reasons beyond your control, the claim must be filed as soon as reasonably possible to receive benefits. If the insurance company has not provided claim forms within fifteen (15) days after the claim notice, you must still provide the insurance company other proof of loss by the date claim forms would be due. The proof of loss should include written proof of the occurrence, type, and amount of loss. If you file a claim for benefits, the insurance company, at its' expense, may have you examined as often as reasonably necessary while a claim is pending. The insurance company also may make an autopsy in case of death where it is not forbidden by law.

Payment of Claims

Your claim will be paid as soon as the insurance company receives proof of loss. If a claim covers benefits for more than four weeks, the insurance company will pay all amounts due at the end of each four weeks. If there are any benefits due at the end of the period claimed, the insurance company will pay them as soon as it receives proof of loss.

Review of Denied Claims (Appeals)

If the insurance company denies your claim and you wish to appeal, you must appeal the denial in writing to the insurance company within sixty (60) days after you receive the written notice from the insurance company that your claim had been denied in whole or in part. If you do not file your appeal within this time period, you will lose the right to appeal the denial. If your claim involves a determination for disability benefits, the appeal must be made in writing no more than one hundred eighty (180) days after you receive the written notice from the insurance company.

Your written appeal should include the reasons you believe that the claim should not have been denied and also should include any additional supporting information, documents, or comments that you consider appropriate.

If Your Claim Is Based on Death or Dismemberment

The insurance company will make a decision on your appeal within a reasonable period of time but no longer than sixty (60) days after it is submitted. This time period may be extended for an additional sixty (60) days if the insurance company determined that there are special circumstances that require an extension. You will be advised in writing of the need for an extension during the initial 60-day period and a determination will be made no more than one hundred twenty (120) days after the date the appeal was submitted.

Review Standards

The review will take into account all comments, documents, records, and other information relating to the claim that you submit without regard to whether such information was submitted or considered in the initial benefit determination.

Notification of Decision

You will be notified in writing if the decision on appeal upholds the initial denial of your claim. The notification will provide:

- The specific reason or reasons for the denial.
- Reference to specific plan provisions on which the determination was based.
- A description of your right to receive (upon request and free of charge) reasonable access to, and copies of, all documents, records, and other information relevant to your claim.
- A statement of your right to bring a civil action under Section 502 of ERISA.

The decision of the insurance company is final and binding on all individuals dealing with or claiming benefits under the Plan for business travel accident insurance coverage.

Limitation on Actions

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court until the claims and appeals procedures described above have been fully exhausted. This means that neither you nor any beneficiary, or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures described above. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant have exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

Designation of an Authorized Representative

You may authorize someone else to file and pursue a claim or file an appeal on your behalf. This authorization must be in writing and signed by you. Any reference in these claims procedures to "you" is intended to include your authorized representative.

Employee Assistance Program

The BJC HealthCare Employee Assistance Program (EAP) helps you deal with the issues in life that can affect your job performance and quality of life. The EAP provides professional counseling and work/life referral services to ensure that you and your family receive the help, guidance, and support that you need.

For All BJC Employees: Your EAP benefits are administered by the BJC EAP.

Eligibility

Eligible Employees

All full-time, part-time, PRN, or per diem employees are eligible to use the employee assistance program.

Eligible Dependents

Any family member who lives in your home is eligible to use the employee assistance program.

When Coverage Begins and Ends

When Coverage Begins

You and your eligible dependents may begin using the EAP on your date of hire.

When Coverage Ends

Coverage for you and your eligible dependents ends the last day of the month in which you terminate employment or otherwise cease to be eligible.

The Cost of Your Coverage

BJC HealthCare provides EAP coverage to you and your eligible dependents at no cost.

EAP Benefits Available

The EAP offers a confidential, short-term solution-focused service in person, by phone and virtual care video. The number of short-term counseling sessions provided under the EAP is based on clinical need.

EAP Short-term Counseling Services

- 24/7 telephone crisis support
- Alcohol and substance abuse
- Family issues
- Loss and grief
- Marital issues
- Maturity and aging
- Mental health
- Parenting issues
- Personal performance and goal setting
- Relationship issues
- Stress management
- Work issues

EAP Work/Life Services

- Childcare resources and referrals
- College planning information and referrals
- Eldercare, resources, and referrals
- Financial resources and referrals
- Legal resources and referrals
- Wellness and lifestyle consultation, information, and referrals

How to Obtain Benefits

In order to obtain benefits or services, you or your dependents simply need to contact the EAP:

- Call 314-747-7490 or toll free at 888-505-6444, or bjceap.com.

PLAN ADMINISTRATION

General Information	
Plan Name and Number	BJC HealthCare Health and Welfare Plan - PN 515
Plan Sponsor	BJC Health System d/b/a BJC HealthCare 4901 Forest Park Avenue, Suite 1200 St. Louis, MO 63108
Employer Identification Number	43-1617558
Participating Employers	• Alton Memorial Hospital • Barnes-Jewish Hospital • Barnes-Jewish St. Peters Hospital • Barnes-Jewish West County Hospital • BJC Behavioral Health • BJC Corporate Health Services • BJC Health System • BJC Home Care Services • Christian Health Services Development Corporation • Christian Hospital Northeast-Northwest • Fairview Heights Medical Group, S.C. • Memorial Hospitals • Memorial Medical Group, LLC • Missouri Baptist Medical Center • Missouri Baptist Hospital of Sullivan • Parkland Health Center (Farmington and Bonne Terre) • Physician Groups, L.C. • Progress West HealthCare Center • St. Louis Children's Hospital
Type of Administration	Third party or insurance company administration
Plan Administrator	The Plan Administrator is the BJC Senior Vice President and Chief People Officer. BJC HealthCare Plan Administrator c/o BJC HealthCare Benefits Department Mail Stop 92-92-248 8300 Eager Road, Suite 300C St. Louis, MO 63144-1412 Phone: 314-362-0529 Plan Administrator duties have been delegated to the applicable insurance company for all insured plans.
Agent for Service of Legal Process	The BJC Plan Administrator, through its general counsel.
Plan Funding	Some benefits are self-insured, and some are fully insured. Contributions/premiums for both self-insured and fully insured benefits are paid by participating employers out of general assets and/or by employees through pre-tax or post-tax salary reductions.
Plan Year	January 1 - December 31

BJC HealthCare Medical and Dental Plan		
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It is a group health plan providing medical (including pharmacy) and dental benefits.	
Plan Disbursements	The Plan is self-insured, and disbursements are made from the general assets of the employer. The Plan Administrator and Benefits Managers provide administrative services only and do not insure or otherwise guarantee the payment of benefits under the Plan. With respect to COBRA premiums, WEX, Inc. acts solely as an administrative collection agent for the employer.	
Benefits Managers	*For medical claims:* Cigna HealthCare P. O. Box 182223 Chattanooga, TN 37422-7223 Phone: 1-800-244-6224 *For pharmacy claims:* Express Scripts, Inc. 1 Express Way St. Louis, MO 63121 Phone: 1-866-273-5779 *Enrollment/Eligibility:* Plan Administrator c/o BJC HealthCare Benefits Department Mail Stop 92-92-248 8300 Eager Road, Suite 300C St. Louis, MO 63144-1412 Phone: 314-362-0529	*For mental health and substance abuse claims:* Cigna HealthCare P. O. Box 182223 Chattanooga, TN 37422-7223 Phone: 1-800-244-6224 *Dental:* Delta Dental of Missouri c/o Appeals Committee 12399 Gravois Road St. Louis, MO 63127-1702 Phone: 314-656-3001 or 1-800-335-8266 *COBRA Administrator:* WEX, Inc. P.O. Box 2079 Omaha, NE 68103-2079 Phone: 866-451-3399 options 1, 2 Fax: 888-408-7224

BJC HealthCare Vision Plan	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It is a group health plan providing benefits for vision care.
Plan Disbursements	Plan benefits are insured, and disbursements are made by the insurance company in accordance with the terms of the group insurance policy specified below.
Insurance Company and Policy Number	Vision Service Plan Insurance Company 3333 Quality Drive Rancho Cordova, CA 95670 Policy # 30016179

BJC HealthCare Employee Assistance Program (EAP)	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It is a group health plan providing employee assistance program benefits.
Plan Disbursements	The plan is self-insured, and coverage is paid for by the employer.
Benefits Managers	BJC Employee Assistance Program 500 Manchester Ave St. Louis, MO 63110

BJC HealthCare Life Insurance Plan (including AD&D)	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It provides group life and accidental death and dismemberment benefits.
Plan Disbursements	Plan benefits are insured, and disbursements are made by the insurance company in accordance with the terms of the group insurance policies specified below.
Insurance Companies and Policy Numbers	ReliaStar Life Insurance Company (Voya®) Policy #: 67757-4GAT (basic life / AD&D, supplemental life / AD&D, and dependent life) Policy #: 67757-4PAI (additional AD&D) 20 Washington Avenue South Minneapolis, Minnesota 55440 Phone: 1-800-955-7736

BJC HealthCare STD Plan	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It provides group short-term disability benefits.
Plan Disbursements	The Plan is self-insured, and disbursements are made from the general assets of the employer. The Benefits Manager provides administrative services only and does not insure or otherwise guarantee the payment of benefits under the Plan.
Benefits Manager and ASO Number	The Lincoln National Life Insurance Company, a Lincoln Financial Group company (Lincoln) P.O. Box 2578 Omaha, NE 68172-9688 Phone: 800-213-1580 ASO #: PD3-840-444999-02
BJC HealthCare LTD Plan	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It provides group long-term disability benefits.
Plan Disbursements	Plan benefits are insured, and disbursements for all benefit payments are made by the insurance company. All benefit determinations are made by the insurance company in accordance with the terms of the plan documents.
Insurance Company and Policy Number	The Lincoln National Life Insurance Company, a Lincoln Financial Group company (Lincoln) P.O. Box 2578 Omaha, NE 68172-9688 Phone: 800-213-1580 Policy #: GF3-840-444999-01
BJC HealthCare Business Travel Accident Plan	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It provides business travel accident insurance.
Plan Disbursements	Plan benefits are insured, and disbursements are made by the insurance company in accordance with the terms of the group insurance policies specified below.
Insurance Company and Policy Number	Life Insurance Company of North America (Cigna) Claims Office, Suite 300 1600 West Carson St. Pittsburgh, PA 15216 Phone: 1-800-238-2125 Policy #: ABL 668025 (business travel)
Flexible Spending Accounts	
Plan Name	BJC HealthCare Flexible Benefits Plan
Type of Plan	The Health Care Flexible Spending Account program is an employee welfare benefit plan providing health care benefits, and it is a component program under the BJC HealthCare Health and Welfare Plan.
Plan Disbursements	Contributions to the health care and dependent care flexible spending accounts are made by employees through pre-tax salary reductions. Disbursements are made directly by the employer from its general assets. WEX, Inc. is a claims-paying agent of the Plan Administrator and all funds sent to WEX, Inc. are employer funds (no separate fund or account secures the benefits under the Health Care Flexible Spending Account program).
Benefits Manager	WEX Health, Inc. (formerly Discovery Benefits, Inc.) P.O. Box 3039 Omaha, NE 68103-3039 Phone: 1-855-620-9975 wexbenefitsyou.com/bjc/
BJC HealthCare Legal Services Plan	
Type of Plan	This Plan is a component program under the BJC HealthCare Health and Welfare Plan. It is an employee welfare benefit plan providing pre-paid legal services.
Plan Disbursements	Employees pay the cost of coverage.
Benefits Manager and Plan Provider	MetLife Legal Plans, Inc. 1111 Superior Avenue E, Suite 800 Cleveland, Ohio 44114-2407 (800) 821-6400 legalplans.com Plan Identification #: 990/2689

Changing Coverage

When You Can Change Your Coverage ("Qualified Change in Status Events")

Because your elections are part of a Section 125 plan, IRS rules determine what changes are permitted outside the normal enrollment period for you and your "qualified" dependents. Your Plan has opted to permit the changes allowed under the regulations. This gives you maximum flexibility if you need to change your annual elections under certain circumstances. Most situations where changes are permitted are described in this summary.

NOTE: Generally, you must request the election change within thirty-one (31) days of the qualified change in status event. However, in the case of a birth, adoption, placement for adoption or in the case of a special enrollment right under the Children's Health Insurance Program Reauthorization Act of 2009, you must request the election change within sixty (60) days of the qualified change in status event. The Plan Administrator has the sole authority to determine whether an event will permit an election change under applicable regulations and rulings of the Internal Revenue Service. If you do not notify the Plan within thirty-one (31) days of a change in status event that causes your dependent to lose eligibility under the Plan, the ineligible dependent's coverage will still terminate as of the last day of the month in which he or she became ineligible. If the removal of the dependent results in a lower premium, premiums will be reduced accordingly on a going-forward basis from the date the corporate benefits office receives notification. Any prior premiums already paid from the date coverage terminated will not be refunded. If you terminate employment and are rehired within thirty-one (31) days of your termination date and during the same Plan year, your most recent benefits election will be reinstated upon rehire, with no gap in coverages. If you are rehired more than thirty-one (31) days after your termination date, or if you are rehired within thirty-one (31) days of your termination date but in a new Plan year, your most recent benefits elections will not be reinstated, and you may make a new election and begin participation upon rehire if eligible.

YOUR SITUATION	YOUR OPTIONS
You gain a new qualified dependent through marriage, birth, or adoption.	• You may add your new qualified dependent to your current medical, dental and/or vision coverage or you may enroll in a different option. • If you previously waived BJC medical, dental or vision coverage, you may enroll yourself, your spouse and any newly acquired qualified dependent child for medical, dental and/or vision coverage. • You may increase your health care flexible spending account election. • You may apply to increase your life insurance (life), accidental death and dismemberment (AD&D) and long-term disability (LTD) coverage. You may also decrease your coverage. • You may change your optional AD&D elections and/or enroll/apply for dependent life and family AD&D coverage. • You may increase or decrease your dependent care flexible spending account election if dependent care expenses are affected. • You may drop coverage for medical, dental, vision, life or AD&D if you become enrolled for similar coverage under your spouse's plan. • If you previously waived legal services coverage, you may enroll for such coverage.
You (the employee) are ordered by a court to provide medical coverage for your qualified dependent child.	• You may enroll the child in your current medical coverage. • If you previously waived medical, dental or vision coverage, you may enroll yourself and the child subject to the order for medical, dental and/or vision coverage.
Your spouse or qualified dependent child loses benefit eligibility (death, divorce, child reaches the limiting age, etc.).	• You may drop medical, dental and/or vision coverage for the affected individual. • You may decrease your life, AD&D and LTD coverage. You may apply to increase your coverage. (Increases for life are subject to approval.) • You may drop family AD&D and dependent life coverage if you no longer have any eligible qualified dependents. • You may decrease your health care flexible spending account election. • You may change your dependent care flexible spending account election if dependent care expenses are affected.
Your previously ineligible spouse or dependent child becomes a qualified spouse or dependent child eligible for benefits.	• You may enroll your qualified spouse or dependent child in your current medical, dental and/or vision coverage. • You may increase your health care flexible spending account election if health plan coverage was lost. You may enroll for dependent life and family AD&D coverage if the qualified spouse or dependent child is now eligible for that coverage.

YOUR SITUATION	YOUR OPTIONS
Your former spouse is required by a court order to provide medical coverage for a child whom you had enrolled in medical coverage under the Plan.	• You may drop the coverage of the child subject to the order.
You become eligible for coverage under another plan because of marriage or a change in your spouse's employment status.	• You may waive medical, dental and/or vision coverage if you become enrolled for similar coverage under your spouse's plan. • You may decrease your life and AD&D elections if you become enrolled for similar coverage under your spouse's plan.
You, your spouse, or your qualified dependent child becomes eligible for coverage under another plan due to a change in your spouse's employment status.	• You may drop medical, dental and/or vision coverage for yourself, your spouse and/or your qualified dependent if you become enrolled for similar coverage under your spouse's plan. • You may change your health care flexible spending account election if you drop yours, your spouse's and/or your qualified dependent's health coverage because you become enrolled for similar coverage under your spouse's plan. • You may decrease your dependent life and family AD&D coverage if your spouse or qualified dependent becomes enrolled for similar coverage under your spouse's plan.
Your qualified dependent child becomes eligible for coverage under another plan due to a change in your dependent child's employment status.	• You may drop medical, dental and/or vision coverage for your qualified dependent child if he/she becomes enrolled for similar coverage under his/her employer's plan. • You may change your health care flexible spending account election if you drop your qualified dependent's health coverage because he/she becomes enrolled for similar coverage under his/her employer's plan. • You may decrease your dependent life and family AD&D coverage if your qualified dependent becomes enrolled for similar coverage under his/her employer's plan.
You, your spouse, or your qualified dependents enroll in Marketplace/Exchange Coverage during an exchange annual enrollment or special enrollment period.	• You may prospectively drop medical coverage for you, your spouse and your qualified dependents, so long as new Marketplace/Exchange coverage is effective no later than the day after the date your BJC coverage ends.
You lose coverage under another plan because of death, divorce, or a change in your spouse's employment.	• You may enroll for medical, dental and/or vision coverage if you lost similar coverage. • You may enroll in a health care or dependent care flexible spending account, or increase your election. • You may apply to increase your life, LTD and AD&D elections.
You lose eligibility for coverage under another plan due to a change in employment status.	• If you previously waived BJC medical, dental or vision coverage, you may enroll yourself, your spouse and/or your qualified dependent under any medical and dental option or vision coverage if similar coverage was lost. • You may enroll in a health care flexible spending account, or increase your election.
Your spouse or your qualified dependent loses coverage under another plan due to a change in employment status.	• You may enroll yourself, your spouse and/or your qualified dependent in medical, dental and/or vision coverage if similar coverage was lost or you may enroll in a different option. • You may enroll, increase, decrease or cease coverage for life, LTD or AD&D coverage. • You may enroll in a health care or dependent care flexible spending account.
Your qualified dependent loses eligibility for coverage under your spouse's plan due to your spouse's death or divorce.	• You may enroll your qualified dependent in your current medical, dental and/or vision option if similar coverage was lost. • If you previously waived medical, dental and/or vision coverage, you may enroll yourself and your qualified dependent under a medical and dental option or vision coverage if similar coverage was lost. • You may increase your health care flexible spending account election if health plan coverage was lost. • You may enroll for dependent life and family AD&D coverage if your qualified dependent lost similar coverage under your spouse's plan.
You, your spouse, or your qualified dependent enrolls in Medicare or Medicaid.	• You may drop medical coverage for the affected individual.
You, your spouse, or qualified dependent loses eligibility for Medicare.	• You may enroll your spouse and your qualified dependent child for medical coverage, or you may enroll the affected individual under your current medical option.

YOUR SITUATION	YOUR OPTIONS
You, your spouse, or qualified dependent loses eligibility for Medicaid or the Children's Health Insurance Program (CHIP) or become eligible for a Medicaid or CHIP premium-assistance subsidy for qualified employer-sponsored health coverage.	• You may enroll your spouse and your qualified dependent child in your current medical coverage, or you may enroll in any other medical option. • If you previously waived coverage you may enroll yourself, your spouse and any newly acquired qualified dependent child in any medical option.
You change from part-time status to full-time status.	• If your cost for coverage is reduced, you may enroll yourself, your spouse, and your qualified dependents for medical, dental or vision coverage or you may change to a higher medical benefit option (e.g., change from BJC Choice to BJC Choice Plus). • You may increase your dependent care flexible spending account election if your dependent care needs change. • You may change your life, and AD&D elections. • You may not change your health care flexible spending account election.
You change from full-time status to part-time status.	• If your cost for coverage is increased significantly, you may change your medical, dental or vision coverage option, but you cannot drop coverage unless you enroll for similar coverage under another employer's plan. • You may decrease your dependent care flexible spending account election if your needs change. • You may change your life, and AD&D elections. • You may enroll yourself for LTD coverage. • You may not change your health care flexible spending account election.
You change from per diem to part-time benefits-eligible status or full-time benefits-eligible status.	• You may enroll yourself, your spouse, and your qualified dependents for BJC medical, dental or vision coverage. • You may enroll in life, AD&D and LTD coverage. • You may elect to participate in dependent care or health care flexible spending accounts. • You may enroll in the legal services plan.
Reduction in hours of service – expected to average less than 30 hours of service per week.	• You may prospectively drop medical coverage for you, your spouse and your qualified dependents even if the reduction in hours does not cause a loss of eligibility under the applicable plan, so long as you enroll in other minimum essential coverage through the Marketplace/Exchange or other employer plan, effective no later than the 1st day of second month following the month that includes the date your coverage dropped.
You have a change in work-site or residence that affects benefit plan choices.	• You may change your life, AD&D and LTD elections. • You may change your medical coverage if the event affects the availability of coverage under your current plan. • You may change your dependent care flexible spending account election if dependent care expenses are affected. • You may not change your health care flexible spending account election.
The annual enrollment and period of coverage under your spouse's plan occurs at a different time than BJC's.	• You may drop coverage for yourself, your spouse, and your qualified dependents if you are enrolled for similar coverage under your spouse's plan. • You may keep coverage for yourself but drop coverage for your spouse and your qualified dependents if they are enrolled for similar coverage under your spouse's plan. • You may not change your health care reimbursement election.
The annual enrollment period and period of coverage under another employer plan occurs at a different time than BJC's.	• You may drop medical, dental or vision coverage for yourself, your spouse, and your qualified dependents if you are enrolled for similar coverage under the other plan. • You may keep medical, dental or vision coverage for yourself but drop coverage for your spouse and/or your qualified dependents if they are enrolled for similar coverage under the other plan. • If you previously waived medical, dental or vision coverage because you had similar coverage under the other plan and you are not re-enrolled during the other plan's annual enrollment, you may enroll yourself, your spouse and/or your qualified dependents under any medical, dental or vision option or a health care or dependent care flexible spending account. • You may enroll your spouse and/or your qualified dependents in your current medical, dental or vision option if they had previously been enrolled for similar coverage under the other plan but are not re-enrolled during the other plan's annual enrollment. • You may enroll for dependent life (subject to evidence of insurability) and family AD&D coverage if similar coverage is dropped under the other plan. • You may drop dependent life and family AD&D coverage if similar coverage is elected under the other plan.

YOUR SITUATION	YOUR OPTIONS
An election change permitted under IRS rules is made under another employer plan.	• You may drop medical, dental or vision coverage for yourself, your spouse, and your qualified dependents if you are enrolled for similar coverage under the other plan. • You may keep medical, dental or vision coverage for yourself but drop coverage for your spouse and/or your qualified dependents if they are enrolled for similar coverage under the other plan. • If you previously waived BJC medical, dental or vision coverage because you had similar coverage under the other plan and an election change is made to drop that coverage, you may enroll yourself, your spouse and/or your qualified dependents under any medical, dental or vision option. • You may enroll your spouse and/or your qualified dependents in your current medical, dental or vision coverage if similar coverage is dropped under the other plan. • You may enroll for dependent life (subject to evidence of insurability) and family AD&D coverage if similar coverage is dropped under the other plan. • You may drop dependent life and family AD&D coverage if similar coverage is elected under the other plan.
You, your spouse and/or your qualified dependents lose group health plan coverage sponsored by a governmental or educational institution, including a: (1) state's children's health insurance program, (2) medical care program of an Indian Tribal government, the Indian Health Service or tribal organization; (3) state health benefits risk pool; or (4) foreign government group health plan.	• If you previously waived medical, dental or vision coverage because you were enrolled for this coverage, you may enroll yourself, your spouse and/or your qualified dependents under any medical and dental option or for vision coverage. • You may enroll your spouse and/or your qualified dependents in your current medical, dental or vision option if they lose the other group health coverage. • You may not change your health care flexible spending account election.
The cost of dependent care changes.	• You may change your dependent care flexible spending account election to reflect an increase or decrease in cost if you change dependent care providers. If you do not change dependent care providers, you may increase your dependent care flexible spending account election only if your dependent care provider is not a relative.
Your need for dependent care increases (your spouse changes from part-time to full-time employment etc.).	• You may increase your dependent care flexible spending account election.
Your need for dependent care decreases (e.g., your child starts kindergarten).	• You may decrease your dependent care flexible spending account election.
You begin an unpaid FMLA leave.	• You may continue your current medical, dental, vision, life, dependent life, AD&D, LTD, legal services and/or your health care flexible spending account and dependent care flexible spending account elections, provided you make any required contributions. • You may revoke your medical, dental, vision, life, dependent life, AD&D, LTD, legal services and/or your health care and/or dependent care flexible spending account elections.
You return from an unpaid FMLA leave.	• You may reinstate any elections you revoked while you were on leave. • You may change elections only if you experienced an event that would have allowed you to change your election if you had not been on FMLA leave. • If you revoked your health care flexible spending account and/or dependent care flexible spending account elections, you may: • Reinstate the annual dollar amount of your elections (your salary reduction amount will increase to make up for missed contributions), or • Reinstate your prior election on a prorated basis (your salary reduction amount remains the same, but your annual election amount is reduced).
You, your spouse, or qualified dependent lose other group medical coverage because (1) employer contributions toward such coverage are terminated, or (2) the coverage was provided through COBRA and the right to COBRA coverage has been exhausted.	• If you previously waived medical coverage because you were enrolled for this coverage, you may enroll yourself, your spouse and/or your qualified dependents under any medical option. • You may enroll your spouse and/or your qualified dependents in your current medical option if they lose the other group coverage or you may change medical options. • You may not change your health care flexible spending account election. • You, your spouse, or qualified dependent incur a claim that would meet or exceed a lifetime limit on all benefits under another employer plan. • If you previously waived medical coverage because you were enrolled for this coverage, you may enroll yourself, your spouse and/or your qualified dependents under any medical option. • You may enroll your spouse and/or your qualified dependents in your current medical option if they lose the other group coverage or you may change medical options.
You, your spouse, or qualified dependent are enrolled in another plan and that plan no longer offers any benefits to the class of individuals of which you or they are a part.	• If you previously waived medical coverage because you were enrolled for this coverage, you may enroll yourself, your spouse and/or your qualified dependents under any medical option. • You may enroll your spouse and/or your qualified dependents in your current medical option if they lose the other group coverage or you may change medical options. • You may not change your health care flexible spending account election.

ERISA RIGHTS

As a participant in the benefit plans, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). This section describes your rights. ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

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

Continue Group Health Plan Coverage

In addition, if you are a participant in a group health plan, you have the right to:

- Continue health care coverage for yourself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan for information regarding your COBRA continuation of coverage rights.
- Receive a copy of the Plan's qualified medical child support order procedures without charge from the Plan Administrator.
- A reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to twenty-four (24) months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion for twelve (12) months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

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

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

Assistance with Your Questions

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

LIMITATION ON ACTIONS

No action shall be brought against the Plan, Plan Administrator or Plan fiduciary in any court unless the claims and appeals applicable to a specific Plan have been fully exhausted. This means that neither you nor any beneficiary or claimant may bring any action against the Plan, Plan Administrator or Plan fiduciary in any court unless you or the beneficiary or claimant have exhausted the administrative claims and appeals procedures. A participant, beneficiary or claimant asserting any action under the Employee Retirement Income Security Act of 1974, as amended ("ERISA"), must do so, if at all, within one (1) year after the "cause of action" accrued. A "cause of action" shall be deemed to have accrued the earliest of when: (i) you, a beneficiary, or a claimant has exhausted his administrative remedies under the Plan; (ii) when the Plan Administrator fails to produce documents in the time or manner required by ERISA in response to your, a beneficiary's or a claimant's written request; (iii) when the claimant first was advised that he was an independent contractor; (iv) when a Plan fiduciary has clearly repudiated the claim (even if not yet filed) and such repudiation is known to you, a beneficiary, or a claimant; or (v) when you, the beneficiary or the claimant first knew or should have known of the action allegedly violating 29 U.S.C. § 1140. Failure to bring an action in court within this timeframe shall preclude you, a beneficiary, or a claimant from bringing any action in court.

Any action in connection with the Plan, whether brought under 29 U.S.C. § 1132 or any other provision of ERISA, by you, a beneficiary under the Plan, or any other person, may only be brought in a federal district court sitting within the Eastern District of Missouri.

DISCLAIMER

The documents contained in this booklet are summary plan descriptions of each of the component programs under the BJC HealthCare Health and Welfare Plan. Because they are only summaries, they may not contain every detail of the Plan.

Each of the plans is governed by the terms of a legal document called a plan document. Some of your benefit plans are self-insured, for example, the BJC HealthCare Medical and Dental Plan. In the case of an insured plan, such as the BJC HealthCare Vision Plan or the BJC HealthCare Life Insurance Plan, the plan document is a policy issued by an insurance company, which provides the benefit. The plan documents for the self-insured plans are available for review in the BJC Plan Administrator's office. The policies for the insured plans are also available for review.

If the provisions of these summary plan descriptions differ from the formal plan documents or policies, the terms of the formal plan documents or policies will govern.

The Plan Administrator reserves the right to amend the BJC HealthCare Health and Welfare Plan or any of the component programs of such Plan, in whole or in part, for any purpose and at any time, without advance notice to you. All amendments will be in writing and will be approved by the Plan Sponsor and executed by the Plan Administrator. Amendments may apply retroactively or prospectively as set forth in the amendment.

With regard to the self-insured plans, the BJC Plan Administrator has the responsibility and sole discretion to interpret the Plan provisions and apply them to specific situations.

The decision of the BJC Plan Administrator, or his or her designee, is final.

Although it is intended that the Plan will be maintained for an indefinite period of time, the Plan Sponsor, by action of the BJC Health System Board of Directors or by any delegated authority from such Board of Directors, at any time may terminate the Plan.

STANDARD OF REVIEW

The Plan Administrator shall perform its duties as the Plan Administrator in its sole discretion, and shall determine what is appropriate in light of the reason and purpose for which the Plan is established and maintained. In particular, the interpretation of all Plan provisions, and the determination of whether a covered individual or beneficiary is entitled to any benefit pursuant to the terms of the Plan, shall be exercised by the Plan Administrator in its sole discretion, and benefits will be paid only if the Plan Administrator decides in its discretion that the applicant is entitled to them. Any construction of the terms of the Plan for which there is a rational basis that is adopted by the Plan Administrator shall be final and legally binding on all parties.

Any interpretation of the Plan or other action of the Plan Administrator made in good faith in its sole discretion shall be subject to review only if such an interpretation or other action is without a rational basis. Any review of a final decision or action of the Plan Administrator shall be based only on such evidence presented to or considered by the Plan Administrator at the time it made the decision that is the subject of the review. Any employer that adopts and maintains the Plan, and any employee who performs services for an employer that are or may be compensated for in part by benefits payable pursuant to the Plan, hereby consents to actions of the Plan Administrator made in its sole discretion and agrees to the narrow standard of review prescribed in this section.