Benefits that fit my life.

2015 Employee Benefits

Franciscan ALLIANCE
Franciscan Alliance (Franciscan) is pleased to provide you with this comprehensive benefit program. We know that you take the health and protection of your family seriously, and we take it seriously, too. That’s why we work hard to make sure you have competitive and affordable benefit choices.

Inside this booklet, you’ll find summaries of each of the benefit plans for which you can enroll, as well as information on how to enroll in your benefits. Be sure to take a closer look at all of the advantages that we are able to offer. It is everything you expect from an organization that is focused on people. We help protect your health. We invest in your future. We do little things that make a real difference.

Be sure to keep this booklet. It can help answer many questions that may arise over the course of the year.
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General Eligibility Information

You are eligible to participate in most Franciscan benefit programs if you are a full-time or regular part-time employee. Part-time and temporary employees are eligible to participate in some of the benefit programs. For more detailed eligibility requirements, please refer to the specific benefit plan summaries located on FRANC.

Dependent Eligibility

Your legal spouse and dependent children are eligible for medical, dental, vision and life insurance coverage if they meet the plan eligibility requirements.

Spouse

If your spouse does not have access to medical coverage from his/her employer, he/she may be enrolled into the healthcare plan, provided a Spousal Election and Coordination of Benefits Questionnaire is completed. This form must be turned in to Human Resources within 30 days after enrollment. A marriage certificate and prior year tax return showing “married filing jointly” or “married filing separately” is also required if your spouse is enrolled. If your spouse has access to medical coverage from his/her employer, he/she may be enrolled under our plan with secondary coverage.

Dependents

Under the Patient Protection and Affordable Care Act (PPACA), you are now able to cover your dependent children up to the end of the month of their 26th birthday in the medical plan, regardless of their full-time student status or their financial dependence upon you. In addition, Franciscan has extended this eligibility to the dental, life, and vision plans.

If your spouse or children no longer qualify for our medical coverage as dependents, they may be able to continue coverage for up to 12 months by paying the full cost of coverage. Contact Human Resources for more information on Continuation of Coverage (COC).

Changing or Electing Benefits During the Year

The choices you make during Open Enrollment remain in place from January 1 through December 31. As a new hire, your benefits will go into effect as of the beginning of the month coincident with or following your hire date and will remain in place until December 31. You cannot add, change or drop coverage until the next Open Enrollment period in November of the following year unless you have a qualifying change of status event.

IMPORTANT: Federal regulations require that all benefit changes, including newborn enrollment, must be completed within 30 days of the event. Contact Human Resources with any qualifying event changes. (Some exceptions under CHIPRA apply.)

If you experience a qualifying event during the year, and would like to make changes to your benefits, please follow the directions in the “Enrolling in Benefits Due to a Qualifying Event” section on the next page.

Your Online Benefits Enrollment

A Quick Overview

You will need to complete your benefits enrollment through our Employee Self Service system. To enroll in your benefits, log on to Employee Self Service as follows:

• From FRANC, click on Employee Self Service
• The login screen to PeopleSoft will appear. Your 6-digit employee ID is used for your User ID, and your Franciscan network password should be used for your Employee Self Service password.

Information Needed to Complete Enrollment

Before you get started with your online enrollment, make sure you have the following information:

• Full legal name(s), birth date(s), Social Security Number(s) for your dependent(s).
• Primary Care Physician (PCP) identification number for each participant (self, spouse and dependents) if enrolling in one of the HMO plans.
• Beneficiary information with current address.

Items that may need to be completed or updated each year:

• Flexible Spending Accounts (FSA)
• Health Savings Account (HSA)
• Dependent information
• Beneficiary information
Enrolling Online

Once you have logged on to PeopleSoft, notice the Menu Items on the left side of the page. Follow these steps to navigate to the enrollment section:

- Click on Employee Self-Service
- Click Benefits
- Click Benefits Enrollment

Enrolling/Changing Information

Continue with the following steps:

- Click the appropriate option to add or edit your coverage.
- Follow the on-screen prompts for each benefit enrollment/change.
- Click Continue or OK to save the information.
- Once you have completed all necessary enrollments/changes, click Submit at the bottom of the Enrollment Summary. If you do not click Submit, your enrollment will not be completed.
- Review all elections to make sure they are correct before clicking on Submit.

If you have a status change event:

- Complete a Notice of Qualifying Event form and submit it to Human Resources, along with the required documentation as listed above.
- The following Thursday after 2 p.m., you should be able to log on to Employee Self Service and change your benefit coverage.
- If you are unable to log in to Employee Self Service or cannot remember your password, please use P-Synch (password reset tool) or contact the Information Services Help Desk at 1-800-346-2322.
- Follow the instructions listed under the “Enrolling Online” section above. You must complete any necessary changes within 30 days of the qualifying event.

Your Medical Benefits

A Quick Overview

All of us have different needs – and no one medical plan is right for every employee or every family. That’s why when it comes to medical benefits, we offer you a choice of medical plans. We want you to be able to choose the plan that makes the most sense for you.

The Franciscan medical plans provide coverage for most of your medical needs — from a doctor’s visit for a sore throat to a hospital stay for major surgery.

The current year’s schedule of benefits for each plan is summarized on the Summary of Benefits Coverage (SBC). Please read the information provided, as you will want to weigh all of your options carefully.

How Our Plans Work

HMO Plans

Health Maintenance Organizations (HMOs) are a type of managed care. When you join an HMO, you select a primary care physician (PCP) from a list of in-network providers. A different PCP may be selected for each participating member of your family. You may change your PCP by contacting ADVANTAGE Health Solutions, our HMO provider, as long as you are not under acute care or treatment.

Most Franciscan health plans allow you to select and enroll with any one of the ADVANTAGE contracted HMO networks.

Services performed by providers outside of your chosen network may not be covered under the Franciscan health plans - please see the schedule of benefits for the health plans available to you in your region.
To choose a PCP for the HMO Plans:

Log on to www.advantageplan.com. Follow these steps:

- Select Find a Doctor, then Group Health Providers, and then Continue Search
- Click Franciscan Alliance Network Members
- Click on the link that applies to your Franciscan Alliance work location
- Click Find a Doctor, then Go
- In the Provider Search Box select a provider type code (i.e. Primary Care Physician)
- Enter your City and State
- Select the network you would like from the drop-down box
- Click Search, search results will appear for review

High Deductible Health Plan (HDHP)

An HDHP is an insurance plan where you are responsible for the deductible amount before the health plan begins to contribute toward the cost of healthcare services or prescription drugs. In an HDHP you play an active role in managing your health and healthcare expenditures. If you enroll in the HDHP, you are not required to designate a PCP.

If enrolled in the HDHP, you can participate in a Health Savings Account (HSA). A HSA is like a personal savings account, but the money in it is used to pay for healthcare expenses. You - not the company - own and control the money in your HSA through payroll deductions is not taxed, and Franciscan will also make a contribution to your account each pay period. Your HSA funds grow tax-free and withdrawals made for qualified healthcare expenses are not taxed. It is important that you keep receipts for all withdrawals from your HSA during the year with your annual income tax returns in case of an IRS audit.

An HSA should not be confused with a Flexible Spending Arrangement (FSA) that you may have elected in the past where funds must be used by the end of the calendar year or they are lost. The funds deposited into an HSA will remain there until you decide to use them. There is no “use it or lose it” rule with an HSA.

To be eligible for an HSA, you must:

- Enroll in the Franciscan Premiere HDHP
- Not enroll in a healthcare FSA
- Not have other health insurance coverage, such as a spouse’s plan, that is not an HDHP
- Not be claimed as a dependent on another person’s tax return
- Not be eligible for Medicare

More detailed information related to HDHP/HSA participation is included in your enrollment materials and on the HSA administrator’s website:

www.WageWorks.com
877-924-3967

Illinois Residents

If you are a resident of Illinois, your medical plan enrollment options are provided through Blue Cross Blue Shield of Illinois (does not apply to employees of Franciscan St. Elizabeth Health). Please see the Summary of Benefits Coverage (SBC) for specifics on these plans or your Human Resources Department for more information.

Prior Authorizations

Prior authorizations are required for many tests and procedures covered by our insurance plans. If you need a specialist, you do not need a referral, but you do need to make sure the provider is in the network. Out-of-network care, unless given prior authorization, may not be covered under the HMO plans.

Urgent Care / Emergency Room Services

Urgent care providers are recommended for urgently needed services when traveling outside the service area or when your primary care physician is unavailable. Urgent care services include unforeseen illnesses or injuries for which treatment cannot be delayed until you return to the service area without your condition growing much worse.

Emergency room visits are covered ONLY when the visit is for a true emergency. An emergency service means a medical condition that arises suddenly and unexpectedly and manifests itself by acute symptoms of such severity, including severe pain, that in the absence of immediate medical attention could reasonably be expected by a prudent lay person who possesses an average knowledge of health and medicine to:

- Place an individual’s health in serious jeopardy;
- Result in serious impairment to the individual’s bodily functions; or
- Result in serious dysfunction of a bodily organ or part of the individual.

Examples include, but are not limited to:

- heart attacks
- strokes
- poisonings
- severe bleeding
- convulsions

Your primary care provider will coordinate all of your medical care. He or she should be contacted when you have a medical emergency or if possible, before seeking emergency services. Required pre-determinations should be processed through your PCP or specialist.
Prescription Drug Coverage

Prescription drug coverage through Franciscan medical plans includes a mandatory mail order provision for maintenance medications. You can save money by using the mail order option because you receive three months of a prescription for two months’ co-pay. You also have the option to fill your maintenance medications at any CVS retail store through the Maintenance Choice program rather than through mail order. Note that if you elect the HDHP, you will not pay copays for your prescriptions - you will be responsible for the full cost of the prescription until you meet your annual deductible.

Franciscan Alliance reserves the right as a Catholic organization to decline coverage of prescriptions for birth control and other drugs that conflict with the religious and ethical directives of the Church, even when used for purposes other than birth control.

The prescription plan has four tiers of coverage. Each tier has a corresponding co-pay (see the Summary of Benefits Coverage (SBC)).

Step therapy, which requires you to try a generic medication before being authorized to use a name brand drug, is also one of the provisions of the prescription drug plan.

Employee Medical Premiums

The current year’s medical plan employee contribution amounts for both full-time and regular part-time employees are found in the Employee Benefits Update.

Full-time and part-time employees whose base rate is between $10 and $15 per hour receive an additional payment per pay-period to help offset the cost of coverage in the medical plan. These payments are based on the employee’s base rate and level of medical coverage elected as shown below:

<table>
<thead>
<tr>
<th>Medical Coverage Tier</th>
<th>Base Rate Less than $10/ Hour</th>
<th>Base Rate at Least $10/ Hour but Less than $13/ Hour</th>
<th>Base Rate at Least $13/ Hour but not more than $15/ Hour</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee Only</td>
<td>$22.50 / pay</td>
<td>$15.00 / pay</td>
<td>$7.50 / pay</td>
</tr>
<tr>
<td>Employee + Spouse</td>
<td>$26.25 / pay</td>
<td>$17.50 / pay</td>
<td>$8.75 / pay</td>
</tr>
<tr>
<td>Employee + Child(ren)</td>
<td>$30.00 / pay</td>
<td>$20.00 / pay</td>
<td>$10.00 / pay</td>
</tr>
<tr>
<td>Employee + Family</td>
<td>$37.50 / pay</td>
<td>$25.00 / pay</td>
<td>$12.50 / pay</td>
</tr>
</tbody>
</table>

Wellness Program

The Mind, Body, Spirit Wellness Program and the corresponding wellness credits associated with the program have been discontinued beginning in 2015. However, various wellness-related activities provided across the system by Franciscan WellCare will continue to be available to all Franciscan employees.

Because Franciscan is committed to improving the health of all employees and their families, you and your family are encouraged to continue to take advantage of the paid preventive services provided under Franciscan’s insurance plans and to continue the healthy lifestyle promoted by the wellness program. However, annual exams and biometric screenings are no longer required. The only required annual screening will be for tobacco use prior to November 1st each year.

If you are a tobacco user, you will pay a surcharge of $50 per pay to be covered by the medical plan in 2015. If your spouse is covered by the plan and is a tobacco user, you will pay an additional surcharge of $50 per pay period.

If we do not have a negative nicotine test on file for you or your covered spouse by the November 1st deadline, you will be considered a tobacco user. The surcharge will be deducted each time benefit premiums are paid.

Completing an approved Tobacco Cessation Program will allow you to ‘earn back’ the surcharge deductions. Information regarding Tobacco Cessation Programs will be communicated individually based on your working location by contacting your local wellness coordinator.

Disease/Health Management Program

Through the CareADVANTAGE program, Advantage Health Solutions empowers members who have conditions like asthma, diabetes, hypertension, and congestive heart failure by providing information on their condition to assist them in maintaining their health. ADVANTAGE provides newsletters and other materials on their specific condition.

If you are considered to be in a high-risk health category, are pregnant or have a chronic health condition such as asthma, diabetes, congestive heart failure, or hypertension and participate in the CareADVANTAGE disease management program, you will be eligible for a discount on your prescriptions for that health-related condition.

This program allows plan members to pay one co-payment instead of the normal two co-payments for a 90-day supply of maintenance medications through the mail-order or Maintenance Choice pharmacy programs. The discount will be applied only to those medications that relate to the chronic condition, pregnancy, or high-risk category.
To participate in the CareADVANTAGE program, you must complete a special Health Risk Assessment (HRA). You can get more information on this program by calling ADVANTAGE Health Solutions at:

1-877-901-2237 Ext. 2303

Your Dental Benefits

A Quick Overview

You’ve heard it before, “Take care of your teeth and they’ll take care of you.” Good oral hygiene and regular check-ups are very important parts of your overall good health.

How Our Plans Work

Our dental plans cover services at different levels depending upon the plan you choose. You decide what level of coverage will best meet the needs of you and your family.

When making a decision on your dental plan, keep in mind that you must carry the same coverage for two years.

Selecting a Provider

We utilize the Delta Dental PPO and Delta Dental Premier networks. You can go to any licensed dentist, but you could lower your out-of-pocket costs and increase your benefits by going to a Delta Dental network dentist.

If you choose a non-network dentist, Delta Dental will make benefit payments directly to you, and you will be responsible for paying your provider.

Delta Dental networks have more than 50,000 dentists practicing in over 71,000 locations nationwide. To find a dentist that participates in the Delta Dental networks, you can contact Delta Dental at:

1-800-524-0149
www.deltadentalin.com

Predetermination of Benefits

An unexpected bill is not a pleasant surprise for anyone. That’s why Delta Dental encourages you to have your dentist submit a treatment plan to Delta Dental before performing services that are or usually cost more than $200. Delta Dental will review the treatment plan and let you and your dentist know what services are covered, what Delta Dental will pay, and what you will have to pay.

If you choose to go to a non-network dentist, you may be billed for any amounts over the usual and customary (balance billing) charges.

How to Access Your Benefits Online

Delta Dental has a great online tool to help you easily access information regarding your dental benefits. Accessing the Consumer Toolkit is easy. You simply need to visit www.toolkitsonline.com and set up your User ID and Password.

You can use the Consumer Toolkit to:

- Verify eligibility
- Review up-to-date benefits information (such as how much of your yearly benefit has been used to date and levels of coverage for specific dental services)
- Pull up a specific claim and see what has been approved and when it was paid
- Print personalized ID cards and claim forms
  (You will not receive an ID card automatically upon enrollment; however, you can print your personalized ID card from this web site.)
- Search the Dentist Directory
- Review oral health information, privacy policies and more

Employee Dental Premiums

The current year’s dental plan employee contribution amounts for both full-time and regular part-time employees are found in the Employee Benefits Update. Premiums are deducted 24 out of 26 pay periods per year. Coverage is elected in two-year increments.

Your Vision Benefits

A Quick Overview

There aren’t many things more important to your daily life than your eyesight, and protecting it should be one of your top priorities. We offer you the opportunity to elect vision benefits that can make caring for your eyes easier and less expensive. The vision benefits are offered through EyeMed Vision Care.

How Our Plan Works

Our plan features a network of eye doctors and facilities that have agreed to provide services at a discounted rate. By using the EyeMed network providers, you save money on vision care.

To encourage you to use preferred providers whenever possible, our plan features lower out-of-pocket costs for EyeMed services through those providers. It’s your choice
to stay in-network or go outside the EyeMed network, but you save money when you use EyeMed providers.

If you decide to take the vision insurance, you will be required to keep the same coverage for two years.

**Selecting a Provider**

EyeMed members have convenient access to more than 16,000 private practice and optical retail locations including LensCrafters, Sears Optical, Target Optical and most Pearle Vision locations.

Locating a participating EyeMed doctor is easy.

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**WHAT DOES THE DENTAL PLAN LOOK LIKE?**

<table>
<thead>
<tr>
<th></th>
<th>Basic Plan</th>
<th>High Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Delta Preferred</td>
<td>Out of Network</td>
</tr>
<tr>
<td>Maximums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Maximums - Class I, II, III</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td>Lifetime Maximum - Class IV</td>
<td>$1,000</td>
<td>$1,500</td>
</tr>
<tr>
<td><strong>Annual Deductibles</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Annual Deductibles - Class I and IV</td>
<td>$0</td>
<td>$0</td>
</tr>
<tr>
<td>Annual Deductible - Class II and III</td>
<td>$50</td>
<td>$25</td>
</tr>
<tr>
<td><strong>Class I: Diagnostic &amp; Preventive Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diagnostic &amp; preventive services (exams, cleanings &amp; children’s fluoride treatments)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Radiographs</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Sealants (dental sealants to prevent decay of permanent molars)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Space Maintainers (to prevent tooth movement)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency palliative treatments (for temporary pain relief)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Class II: Basic Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Oral surgery services (extractions and dental surgery)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Minor restorative services (to repair damaged teeth, crowns)</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>Periodontics (to treat diseases of the gums and supporting structures)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>Endodontics (to treat teeth with damaged nerves/root canal)</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Class III: Major Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Major restorative services (when teeth cannot be restored with another material/crowns)</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td>Prosthodontics (to replace missing natural teeth/bridges/dentures/implants)</td>
<td>50%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Class IV: Orthodontic Treatment</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Orthodontic services (to age 19)</td>
<td>50%</td>
<td>50%</td>
</tr>
</tbody>
</table>

Cleanings are allowed every six months (providing the annual maximum has not been met) with no deductible and no out-of-pocket costs if they are at usual and customary rates.

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**EyeMed Customer Care Center**

1-866-723-0596

Access Network of Providers

[www.enrollwitheyemed.com/access](http://www.enrollwitheyemed.com/access)

**Using Your Vision Benefits**

At your appointment, the participating doctor will provide an eye examination and determine if prescription eyewear is necessary. Your doctor will itemize any non-covered charges and have you sign a form to document that you received the services. You are responsible for paying the doctor any applicable co-payments and additional costs resulting from non-covered services or outside-the-plan reimbursement limits.
<table>
<thead>
<tr>
<th>Basic Benefits</th>
<th>In-Network Copay</th>
<th>Out-of-Network Allowance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exam with dilation</td>
<td>$0</td>
<td>Up to $55</td>
</tr>
<tr>
<td>Retinal Imaging</td>
<td>Up to $39</td>
<td>n/a</td>
</tr>
<tr>
<td>Frames</td>
<td>$150 allowance, 20% off of the balance over $150</td>
<td>Up to $75</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Standard Plastic Lenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Single</td>
<td>$0</td>
<td>Up to $25</td>
</tr>
<tr>
<td>Bifocal</td>
<td>$0</td>
<td>Up to $40</td>
</tr>
<tr>
<td>Trifocal</td>
<td>$0</td>
<td>Up to $55</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Lens Options</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Tint</td>
<td>$15</td>
<td>n/a</td>
</tr>
<tr>
<td>UV coating</td>
<td>$15</td>
<td>n/a</td>
</tr>
<tr>
<td>Standard scratch resistance</td>
<td>$15</td>
<td>n/a</td>
</tr>
<tr>
<td>Standard polycarbonate (adults &amp; children)</td>
<td>$0</td>
<td>n/a</td>
</tr>
<tr>
<td>Standard anti-reflective</td>
<td>$45</td>
<td>n/a</td>
</tr>
<tr>
<td>Standard progressive</td>
<td>$65</td>
<td>n/a</td>
</tr>
<tr>
<td>Other add-ons and services</td>
<td>20% off retail price</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Contact Lenses</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Conventional</td>
<td>$130 allowance, 15% off balance over $130</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Disposables</td>
<td>$130 allowance</td>
<td>Up to $104</td>
</tr>
<tr>
<td>Medically necessary</td>
<td>Paid in full</td>
<td>Up to $200</td>
</tr>
<tr>
<td>Contact lens fit and follow-up</td>
<td>Up to $55</td>
<td>n/a</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Frequency of Services</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Exams</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td>Frames</td>
<td>Once every 24 months</td>
<td></td>
</tr>
<tr>
<td>Standard plastic lenses</td>
<td>Once every 12 months</td>
<td></td>
</tr>
<tr>
<td>Contact lenses</td>
<td>Once every 12 months</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Additional Discounts</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Items not covered by the plan at network providers (some restrictions apply)</td>
<td>20% discount</td>
<td></td>
</tr>
<tr>
<td>2nd complete pair of glasses at network providers</td>
<td>40% discount</td>
<td></td>
</tr>
<tr>
<td>Additional conventional contact lenses after annual benefit has been used</td>
<td>15% discount</td>
<td></td>
</tr>
<tr>
<td>LASIK and PRK vision correction procedures</td>
<td>15% off retail or 5% off promotional pricing</td>
<td></td>
</tr>
</tbody>
</table>
Employee Life Insurance

• Basic Life Insurance – Franciscan Paid
• Supplemental Life Insurance – Employee Paid

Accidental Death and Dismemberment Insurance (AD&D)

• Basic AD&D – Franciscan Paid
• Supplemental AD&D – Employee Paid
• Travel Accident Insurance - Franciscan Paid

Dependent Life Insurance

• Coverage for Spouse and Child(ren) – Employee Paid

How Our Plans Work Together to Protect Your Family

The life insurance plans offered by Franciscan are designed to work together to provide employees with the tools they need to achieve financial security.

Employee Life Insurance

You automatically receive at no charge basic life insurance in the amount of one times your annual base pay if you are a full-time or regular part-time employee with minimum coverage of $10,000 and maximum coverage of $750,000.

You may also elect to purchase an additional flat amount of life insurance in $5,000 increments up to a maximum of 6 times your annual base pay ($750,000 maximum - subject to evidence of insurability provisions).

Basic life and basic AD&D insurance coverage becomes effective on the first of the month following your hire or change from a non-benefits-eligible position to a benefits-eligible position.

Accidental Death and Dismemberment Insurance

You automatically receive accidental death and dismemberment insurance for yourself in an amount equal to your basic life insurance. This benefit is also provided to you at no cost by Franciscan.

In addition, when you enroll in the Supplemental Life Insurance benefit, you automatically receive AD&D insurance equal to the benefit amount you selected for Supplemental Life Insurance. In the event of your accidental death, these benefits (both the life and AD&D insurances) are paid to your beneficiary and are non-taxable.

If an accident results in a qualifying dismemberment, you (as the covered employee) will receive benefits equal to 50 percent or 100 percent of the insured amount based on the injury. Benefits paid are subject to taxes.
Travel Accident Insurance

*Franciscan* also provides travel accident insurance for all employees. Your coverage under this program ranges from $100,000 to $200,000, based on your employment classification, and it covers all *Franciscan* business travel and limited personal travel.

This policy does not cover disability or loss due to illness, disease, or bodily infirmity. Our existing group life insurance policy covers these situations. This is strictly an accident policy covering death, dismemberment, or loss of sight.

More information on this benefit is available from Human Resources or on the Intranet.

**Dependent Life Insurance**

You may elect from the following three levels of dependent life insurance coverage:

<table>
<thead>
<tr>
<th>Children</th>
<th>Spouse</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child coverage $5,000</td>
<td>N/A</td>
</tr>
<tr>
<td>(Available to single employees only)</td>
<td></td>
</tr>
<tr>
<td>Child $5,000</td>
<td>$5,000</td>
</tr>
<tr>
<td>Child $10,000</td>
<td>$10,000</td>
</tr>
</tbody>
</table>

Benefits are paid to you (as the employee and beneficiary) in the event of your spouse’s or dependent child’s death. Dependent premium rates are included in the Employee Benefit Update.

**Statement of Health Questionnaire (Evidence of Insurability)**

You may enroll for Supplemental Life and/or AD&D coverage during your initial enrollment period without providing a *Statement of Health Questionnaire* as long as you are actively at work and the following conditions are met:

- Your enrollment takes place within 30 days of your first becoming eligible for benefits and prior to the enrollment period deadline;
- You have not been hospitalized within 90 days of enrollment; and
- You are enrolling for coverage that does not exceed $350,000 of supplemental life coverage.

If you do not meet the above conditions, you must complete and submit a *Statement of Health Questionnaire* to the insurance company. The *Statement of Health Questionnaire* can be obtained from Human Resources or on FRANC.

If you are already enrolled in Supplemental Life, you may increase your coverage up to $25,000 each annual open enrollment period without submitting a *Statement of Health Questionnaire*.

You may enroll your spouse or dependent for Dependent Life Insurance during your initial enrollment period without providing a *Statement of Health Questionnaire* as long as your spouse and/or child are performing their normal activities and the following conditions are met:

- Your enrollment takes place within 30 days of your first becoming eligible for benefits; and
- Your dependent has not been hospitalized within 90 days of enrollment.

If your dependent does not meet the above conditions, your dependent will need to complete a *Statement of Health Questionnaire*.

If a *Statement of Health Questionnaire* must be submitted, your supplemental or dependent coverage will not go into effect until you have received confirmation from the insurance carrier that your *Statement of Health Questionnaire* was received and coverage is approved.

**Beneficiaries**

Life insurance benefits are paid to your designated beneficiary in the event of your death. When you first enroll for life insurance benefits, you will be asked to name your beneficiary. If there is no designated beneficiary, the life insurance benefits are paid according to the provisions of the life insurance policy and applicable state or federal law.

You are always the beneficiary of the dependent life insurance.

You should review your beneficiary information at least once a year and update it any time you have a family status change (such as marriage, divorce, birth or death). Log on to Employee Self-Service to review your beneficiary designation or make updates:

- Click on Benefits
- Click on Insurance Summary
- Click on Life and AD&D and/or Supplemental Life
- If you don’t have beneficiaries listed yet, click Edit
- Click Add a New Beneficiary

You can change percentages or add new beneficiaries. You cannot delete or change information on existing beneficiaries. If you have a beneficiary that is no longer valid, do not allocate any percentage or flat amount to that individual.

**Tax Implications**

Life insurance coverage in excess of $50,000 is assessed an imputed income tax — a “user tax” required by current tax regulations. A dollar value, based on your age, is assigned to life insurance coverage over $50,000. The imputed income tax is then reported as part of your taxable income. However, life insurance benefits paid to your designated beneficiary are non-taxable when received.
Dependent life insurance coverage is an after-tax expense. The cost of this coverage is deducted from your pay after taxes have been deducted.

**Supplemental Life Premium Rates**

Current supplemental life insurance premium rates are calculated as shown in the examples below:

**Example 1:**
Supplemental life insurance for the maximum of 6 times basic annual earnings assuming your base pay is $31,000 and you are age 39:

- **Step 1:** $31,000 x 6 is $186,000 rounded to the nearest $5,000, or $185,000 maximum flat amount benefit available
- **Step 2:** $185,000 / $1,000 = 185
- **Step 3:** 185 x $0.09* = $16.65 per month
- **Step 4:** $16.65 / 2 pay periods per month = $8.33 per pay period

**Example 2:**
Supplemental life insurance for a flat amount of $350,000 assuming your base pay is $46,000 and you are age 39.

- **Step 1:** Max Available = $46,000 x 6 or $276,000 rounded to the nearest $5,000 or $275,000 ($350,000 is not available)
- **Step 2:** $275,000 / $1,000 = 275
- **Step 3:** 275 x $0.09* = $24.75 per month
- **Step 4:** $24.75 / 2 pay periods per month = $12.38 per pay period

*The above rates are examples only and the calculations also include the cost of Supplemental AD&D coverage. Current Supplemental Life insurance premium rates are shown in the *Employee Benefit Update*.

**Your Flexible Spending Accounts**

**A Quick Overview**

Believe it or not, flexible spending accounts (FSAs) can be among the most valuable benefits we offer. They’re simple to use and can save you money.

The healthcare FSA allows you to pay for qualified healthcare expenses with before-tax dollars. In effect, you don’t have to pay taxes on the money you spend on healthcare.

A dependent care FSA gives you the same tax and money-saving advantages for childcare and certain other dependent care expenses. Please take note that the dependent care FSA covers expenses related to the care of your dependents. It does not cover healthcare expenses for your dependents.

You may contribute up to $2,500 a year to the healthcare FSA, and up to $5,000 a year to the dependent care FSA. There is a minimum election of $260 per year. The funds you contribute to your FSA are not subject to Social Security, or federal and state income tax.

You cannot participate in the healthcare FSA if you are enrolled in the Premier HDHP (High Deductible Health Plan) with a Health Savings Account (HSA).

**How FSAs Work**

Flexible spending accounts are easy to use. Each year the amount you elect is credited to your FSA account, and that amount is loaded onto your FSA debit card. Each pay period, 1/26th of the amount you elected is automatically deducted from your paycheck to fund your FSA account. Then, as you incur and pay for eligible expenses, your flexible spending account is reduced by those expenditures. You can stop or change your contribution amount only if you have a qualifying family status change.

**Healthcare Expenses**

You can receive reimbursement before your account balance is sufficient to cover the expense.

Here’s an example:

- You elected to have $1,000 deposited in your healthcare FSA for the calendar year.
- In February, you have surgery and your out-of-pocket costs are $2,000.
- Although your contributions to this point have amounted to only $76.92, you are reimbursed the full $1,000 that you will contribute over the course of the year.
- Payroll deductions continue throughout the year up to the $1,000 you elected.

**Dependent Care Expenses**

You only receive reimbursement of funds that are currently available in your account to cover dependent care expenses.

For example:

- You elected to have $2,000 deposited in your dependent care FSA for the calendar year.
- At the end of January, daycare expenses for your 2-year-old were $500.
- You are reimbursed $153.84 — your account balance at the time you filed your expenses for reimbursement.
Eligible Expenses

In general, you may use your spending accounts to fund the following healthcare and dependent care expenses:

Healthcare FSA
• Deductibles, co-payments and co-insurance
• Eye exams, glasses and contact lenses
• Prescription drugs
• Certain over-the-counter drugs (must provide Rx for OTC)
• Hearing exams and hearing aids
• Certain weight loss and smoking cessation programs
• Charges over usual and customary
• Any other healthcare expenses that would normally be an itemized deduction under the Internal Revenue Code (certain restrictions apply - see the plan summary for details)

Dependent Care FSA
• Daycare expenses for a child up to age 13
• Daycare expenses for a child over the age of 13 who is physically or mentally impaired
• Services provided that enable you (and your spouse) to work
• Expenses for the care of an incapacitated spouse or elderly parent (certain restrictions apply)

Using Your FSA

It’s easy to use your FSA to pay for eligible expenses. You have two options to receive reimbursement:

FSA Benefits Card
When you enroll in a Healthcare FSA, you receive an FSA Debit Card. This card may be used to pay for eligible healthcare expenses such as co-payments at your doctor’s office, prescriptions, and/or child care expenses. The FSA Debit Card may be used anywhere that MasterCard is accepted.

When you make a purchase using your FSA Debit Card, the amount is verified against a list of common co-payment amounts. If your purchase cannot be substantiated, you will be required to provide a receipt to verify your purchase. The IRS requires that you be audited for any purchase that is questionable. Therefore, it is important to keep all receipts from purchases made with your FSA Debit Card.

Ineligible expenses charged through on your FSA Debit Card must be paid back (redeposited) into your FSA or your card will be deactivated.

Reimbursement Forms

If you prefer not to use the FSA Debit Card, you may file for payment of your flex spending expenses by completing the appropriate form. To obtain a reimbursement form, visit or call the FSA Administrator at:

www.WageWorks.com
877-924-3967

Complete the form, attach your receipts, and fax the information to the number below. You may also mail the original to:

WageWorks
P.O. Box 14053
Lexington KY 40512
Fax 877-353-9236

Reimbursement checks will be sent to your home, usually a 48-hour turnaround time after you submit your reimbursement form. Direct deposit for your reimbursements is also available by completing and returning a direct deposit form.

Deadline for Submitting Expenses for Reimbursement

All healthcare and dependent care expenses incurred in a given year must be received by WageWorks by June 30 of the following year. Claims received after that date are not eligible for reimbursement.

In 2013, the IRS passed an amendment to the FSA regulations that allows up to $500 of healthcare FSA contributions to “roll over” to the following year. These rollover funds cannot be used for eligible FSA expenses incurred during the following year until after the claims filing period for the previous year has passed (e.g. June 30, 2014 for 2013 contributions). Any money left in your FSA over and above $500 at the end of the year is forfeited. IRS rules only allow you to make changes to the amount you deposit into your accounts if you have a qualifying family status change, so plan carefully.

Checking the Status of a Reimbursement or Account Balance

You can contact WageWorks at 877-924-3967 or visit their web site at www.WageWorks.com at any time to check your account activity. (A user ID and password are required.)

Exclusions

Funds in your reimbursement accounts may not be used to pay for:
• Birth control in any form, even if medically necessary
• Insurance premiums
• Deductions for items you have claimed at the time you file your federal income tax return
There are times in your life when you know you’re going to need the services of an attorney: making a will, buying real estate, debt matters, adoptions and many other occasions. But hiring an attorney can be an expensive proposition.

Now it can be a lot less expensive. You can enroll in a great benefit — prepaid legal services offered through Hyatt Premier Legal Plan, a national network of attorneys. When you sign up for the plan and you need an attorney, you simply call the toll-free number provided.

The cost for this benefit is shown in the Employee Benefits Update and is deducted from your paycheck after tax.

Using Your Legal Benefits

The legal services covered by the plan are fully paid by the plan when you see a plan attorney, with certain restrictions. You can use the plan as often as you need legal representation, and there are no dollar limits on your use of a plan attorney. Also, if you wish to use an attorney that does not participate in the Hyatt plan, Hyatt will reimburse you according to a set fee schedule.

You must contact Hyatt before you talk with an attorney directly. When you want to talk with a lawyer, simply call the Hyatt Client Service Center at:

1-800-821-6400

or visit the Hyatt Legal Plans web site at:

www.legalplans.com

Arranging for Legal Services by Telephone

Call the customer service center at 1-800-821-6400 during the times listed below:

Monday – Thursday: 8 a.m. - 7 p.m. (EST)
Friday: 8 a.m. - 6 p.m. (EST)

Identify yourself as a Hyatt plan participant and be prepared to provide the covered employee’s Social Security number.
At this time, a Hyatt representative will:

- Verify your eligibility for services
- Make an initial determination of whether and to what extent your case is covered
- Provide you with a case number
- Provide a telephone number of the plan attorney most convenient to you

You may then call the attorney to discuss your concern or, if appropriate, make an appointment for an office consultation. Evening and Saturday appointments are often available.

**NOTE:** You must call Hyatt prior to contacting any attorney, or your charges will not be covered.

**Arranging for Legal Services Online**

After reaching the site at [www.legalplans.com](http://www.legalplans.com), click the Members Login icon at the top of the page to be redirected to a secure area of the web site. Enter your Social Security number and select the option for Obtain Case Number. You’ll also be able to search for a plan attorney who is convenient for you. After receiving a case number, you can then call the attorney to discuss your concern or, if appropriate, make an appointment for an office consultation.

**Using an Out-of-Network Attorney**

If you wish to use an attorney who does not participate in the Hyatt plan, tell the client service representative that you want to use your own attorney. Hyatt will reimburse you for these attorney fees in accordance with a set fee schedule. Fee information is available from Hyatt at 1-800-821-6400.

**Obtaining Emergency Legal Services**

Emergency service is also available by calling the number below 24 hours-a-day / 7 days a week.

1-800-821-6400

**What are the Exclusions?**

The **Franciscan** legal plan excludes appeals; class actions; matters that Hyatt Legal Plans deems frivolous, non-meritorious or unethical; divorce (except for telephone and office consultations); and any employment-related matters. For a complete list of exclusions, contact Hyatt Legal Plans.

**More Information**

For more information, contact Hyatt Legal Plan services online or by phone:

[www.legalplans.com](http://www.legalplans.com)

Click - Thinking About Enrolling

Enter - 3910010 or 100010

Phone: 1-800-821-6400

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**Legal Plan Coverage**

**Estate Planning Documents**

- Simple and complex wills
- Trusts (revocable and irrevocable)
- Living wills
- Codicils

**Family Law**

- Premarital agreement
- Uncontested adoption
- Uncontested guardianship
- Name change

**Advice and Consultation**

- Review of immigration documents
- Preparation of affidavits and powers of attorney

**Juvenile Matters**

- Juvenile court defense

**Consumer Protection**

- Disputes over consumer goods and services and small claims assistance.

**Document Review**

- Any personal legal document

**Document Preparation**

- Affidavits
- Deeds
- Demand letters
- Mortgages

**Financial Matters**

- Negotiations with creditors
- Debt collection defense
- Identity theft
- Personal bankruptcy
- Tax audit representation

**Traffic Offenses**

- Defense of traffic tickets (excludes DUI)
- Driving privileges restoration (includes license suspension due to DUI)
Your Retirement Benefits

Focusing on Your Future

To be successful in healthcare today, we must truly care about our patients, be responsive to their needs, and be flexible to new ideas and change. We’ve incorporated these same qualities – Care, Responsiveness, and Flexibility – into the retirement program we offer to all Franciscan employees.

Care
We care about your financial future. That’s why our retirement program is designed to provide a competitive and secure benefit that grows over the years so that when you retire, you’re assured a measure of financial security.

We care that you’re involved in planning for your future, too. That’s why our program also gives you a convenient and systematic way to save for your future on a tax-favored basis.

In addition to our system-sponsored retirement program, Franciscan is committed to communicating with you regularly about retirement planning and providing you with the necessary educational tools so you can make informed savings and investment decisions.

Responsiveness
Our program responds to the diverse needs of our employees – no matter how much of your working career you spend with Franciscan. The program provides benefits that meet the needs of all our employees by offering an account-based benefit that grows over time, a monthly benefit based on your pay and service, or a minimum monthly benefit, whichever provides the highest amount.

Flexibility
Our program is flexible. It offers both security and savings features. It also offers many different ways you can have your benefit paid when you retire. And finally, it offers flexible saving and investing opportunities.

New Retirement Program

Effective January 1, 2014, employees of all Indiana Franciscan healthcare entities, will be eligible to participate in the new system-wide Franciscan Retirement Security Program. The new Franciscan Retirement Security Program includes the following retirement plans, which combine to provide you with a means to attain financial security for the future. Please see the retirement program summary brochure for more details. Employees working for Franciscan Illinois entities will continue to participate in the same retirement program in place on December 31, 2013.

Franciscan Retirement Plans

- 403(b) Plan
- 401(k) Plans (all 401(k) plans were frozen 12/31/13)
- 457(b) Plan
- 401(a) Employer Contribution Plan
- Pension Security Plan

Social Security

And don’t forget Social Security – it’s another important source of retirement income. You and Franciscan are partners in funding your Social Security retirement benefits.

Participation Requirements

As an employee of Franciscan you are eligible to participate immediately in the retirement program by deferring a portion of your compensation to the 403(b) plan and the 457(b) plan. You will also be eligible to participate in the defined benefit pension plan after you complete one year of service with Franciscan. Participation in the 401(a) Employer Contribution Plan for those employees who are either not currently participating in, or are not vested in, the Pension Security Plan as of January 1, 2014, begins after attainment of age 21 and 12 months with 1,000 hours of service.

403(b) Plan

The 403(b) plan provides an easy and convenient way for you to put money aside to help meet your financial goals for retirement. The plan offers the following features:

- The convenience of payroll deductions;
- The advantage of tax-deferred or after tax savings through the Roth 403(b) option; and
- A choice of contribution amounts and investment funds

You may begin contributing to the 403(b) plan immediately upon hire. You can contribute up to 100% of your pay up to the IRS allowable limit ($17,500 in 2014). In addition, if you are 50 years of age or older by the end of the tax year,
you can contribute an additional $5,500. You can change the percentage or the amount you are contributing at any time. For more information on the 403(b) plan, please call or visit your VALIC financial advisor:

1-888-568-2542
www.VALIC.com

457(b) Non-Qualified Tax-Deferred Compensation Plan

The 457(b) plan is a non-qualified tax-deferred plan that works much like a 403(b) or 401(k) plan. Your contributions grow tax-free until withdrawn at retirement or termination of employment. The maximum contribution amount for 2014 is $17,500. It is possible to contribute to both the 403(b) and the 457(b), but you must contribute at the IRS annual maximum rate in the 403(b) plan to also contribute to the 457(b). Please see your VALIC financial advisor for more information or to sign up for the 457(b) program.

401(a) Employer Contribution Plan

If you were not currently participating in or not vested in the Pension Security Plan as of January 1, 2014, you will be eligible for annual non-elective contributions by the company amounting to the greater of $1,800 or 3% of your eligible compensation beginning with the plan year ending on December 31, 2014. You must work at least 1,000 hours to be eligible for a contribution, and at least 1,820 hours to receive the $1,800 minimum contribution. The minimum benefit dollar amount of $1,800 is prorated for those participants who are credited with at least 1,000 but less than 1,820 hours during the plan year.

If you are an employee of a Franciscan Illinois entity, your employer contribution to your retirement plan will continue to be calculated as in the past.

Vesting
Vesting refers to your “ownership” of the funds in the plan. You are always 100% vested in your own contributions and rollover contributions, plus any earnings they generate. Employer contributions to the plan, plus any earnings they generate, are fully vested after 3 years of service. A service year is at least 1,000 hours of work during the calendar year.

Pension Security Plan

All employees of Franciscan Indiana healthcare companies who meet eligibility requirements will also participate in the Franciscan Alliance Pension Security Plan effective January 1, 2014. This is a defined benefit retirement plan that is funded 100% by Franciscan. This plan is designed to provide a monthly pension income benefit upon retirement, subject to eligibility and vesting requirements.

Although the normal retirement age under this plan is 65, a reduced benefit is available starting at age 55 for vested employees with a minimum of 10 years of credited service.

You will automatically be enrolled in the Pension Plan on the first day of the quarter after which you have met both of the following criteria:

- 21 years of age or older
- Completed 12 months of service during which you worked at least 1,000 hours

You will have a vested pension benefit after completing 5 years of credited service. Your benefits are calculated based on your years of service and highest consecutive seven years of pay.

Estimating what your monthly pension benefit will be upon your retirement can be challenging. Active employees will receive a written accrued benefit statement each year. Your VALIC financial advisor is available to assist you with estimating your projected retirement benefits from all sources to aid in planning your retirement strategy. This is a free resource for all employees, and you are highly encouraged to take advantage of it.

Your Other Benefits

A Quick Overview

As an employee of Franciscan, you have access to many great benefits. Only some of those benefit plans require you to enroll every year. Those benefits that don’t require you to enroll every year are summarized here.

Paid Time Off (PTO)

Franciscan provides paid time off to regular full-time and regular part-time employees (.5 FTE and above) to be used for holidays, vacations, illnesses or injuries, and other times you are unable to be at work. The amount of PTO you earn is determined by your position classification and length of service with Franciscan.

PTO hours are credited based on eligible hours paid during each pay period. Some paid hours are not considered for PTO accrual purposes including, but not limited to, pay received while on short-term or long-term disability, PTO pay-outs, and hours worked over 80 per pay period.

You begin accruing PTO immediately upon employment and may accumulate up to one and one-half times your annual benefit at any given time. Once the maximum PTO balance has been reached, further PTO accruals will cease until you have used enough PTO to fall below the maximum balance permitted. Please refer to your Employee Handbook or the Corporate Paid Time Off Policy on FRANC for more information.
Short-Term Disability Pay

Short-term disability (STD) pay is a benefit provided to you at no cost by Franciscan. STD helps provide replacement income during approved medical leaves of absence. You are eligible for short-term disability pay if you are a full-time employee (.875 FTE and above) and you have worked full-time for at least 6 months prior to the beginning of your leave. The effective date of your coverage is the first day of the month coincident with or following 6 months of full-time active employment.

Short-term disability pay is available after a seven-calendar-day elimination period and can be paid up to a maximum of 180 days. Upon certification of medical disability by your attending physician and approval by Sedgwick (the Franciscan Leave Administrator), STD payments will be available to replace 60 percent of your regular base pay. If you have any frozen reserve sick time or extended sick leave hours available, these must be exhausted before STD benefits will be paid.

Please refer to the Franciscan Short-term Disability Plan summary for specific information on STD benefits or contact Human Resources.

Long-Term Disability Pay

Long-term disability (LTD) income replacement protection is automatically provided at no cost to regular full-time employees (.875 FTE and above). Extended illnesses or injuries of more than 180 days may qualify you for LTD payments amounting to 60 percent of your regular base pay. If you have any frozen reserve sick time or extended sick leave hours available, these must be exhausted before LTD benefits will be paid.

You are eligible for LTD coverage effective on the first day of the month coincident with or following 6 months of active full-time employment. Please refer to the Franciscan Long-term Disability Plan summary for specific information on LTD benefits or contact Human Resources.

Employee Paid Short-Term and Long-Term Disability

Regular part time employees (.5 - .874 FTE) may purchase group disability coverage through Franciscan. These plans model the plans provided to full time employees, except as a regular part-time employee you pay 100 percent of the cost.

Employee Assistance Program (EAP)

You and your family have access to a valuable resource — the Employee Assistance Program — at no cost to you. The EAP is completely confidential. No one will know you visited the EAP unless you tell them.

The EAP offers assessment; short-term problem resolution; referral, if necessary; and follow-up to employees and/or family members who want assistance.

Contact the EAP for help with problems before they affect your health, family life, or job performance.

Central Indiana Region
1-317-782-7900 or 1-800-963-0060

All Others:
1-219-662-3730 or 1-800-747-7262

Educational Assistance Program

As a leading health care system, Franciscan has long recognized the importance of a quality education for our employees and the value it brings to our organization. A single, corporate policy outlining our Educational Assistance Program, and establishing guidelines whereby Franciscan will reimburse expenses incurred by eligible employees who are continuing their education will be effective on January 1, 2015. This corporate policy replaces any existing tuition reimbursement policy or program (excluding the School of Nursing/Cohort program).

For some Franciscan entities, the standardized maximum reimbursement rates will be an increase from previous programs, and for some entities, it will be a decrease. This new program will allow us to provide fair and consistent educational support to employees across the system, while utilizing our resources in the most efficient way possible.

Educational assistance may be provided to eligible employees based upon funding available at the time of the application and the need for individuals with such educational training. Priority will be given to those eligible employees pursuing degrees that qualify them for key, hard-to-fill positions within the organization.

Key provisions of the policy are summarized below. Please refer to the Corporate Educational Assistance Policy on FRANC for complete details.

Eligibility

- You must be a regular part-time or full-time employee from the start of the course through the reimbursement request.
- You must be free of any written warning in last 12 months.
- You must complete the approved course(s) with a minimum grade of “C” for undergraduate courses, “B” for graduate courses, or “P” in a “Pass/Fail” system.
- You must submit an Educational Assistance Application prior to the beginning of the course to the Human Resources Department, or Education Department as applicable, and follow the approval process for your Franciscan entity.
Approved Courses

- Must satisfy *Franciscan’s* right to give priority to certain positions deemed as critical need.
- Must be offered by accredited institutions.
- Must be applicable to a degree program that relates to your present position or possible future position, or beneficial to your work or work that you may be reasonably expected to perform in the future.

Reimbursement

- Reimbursement is for tuition only, calculated on a per-credit-hour basis, as determined by an aggregate of several benchmark institutional rates. Maximum per-credit-hour rates for 2015 calendar year are $300 for undergraduate courses and $430 for graduate courses.
- Maximum reimbursement per calendar year is $3,000.

Example:

If you request reimbursement in 2015 for tuition reimbursement that was approved for fall 2014 classes, grades must be turned in by January 31, 2015 to count toward the 2014 calendar year reimbursement. Grades turned in after January 31, will count toward the reimbursement paid in 2015 and count toward the $3,000 maximum 2015 annual reimbursement.

- If you have been approved for reimbursement, met the minimum grade requirements, and submitted documentation within 30 days of completing the course, you will be reimbursed at 100% up to the maximum rates listed.
- If you receive tuition reimbursement, you must remain with any Franciscan entity after the completion of the course(s) and work at least 2,080 hours (equivalent to a full-time position of 40 hours per week for one year). If you leave the organization before then, you will be required to pay back the full assistance received.
- Meeting eligibility requirements does not guarantee approval for educational assistance, and approval or reimbursement is not a promise of employment, position or compensation at a particular level.

The complete Educational Assistance Program Policy and the Frequently Asked Questions document are available on FRANC for more information.

Discount Programs

### MetPay Home and Auto Insurance

As a benefit-eligible employee, you have access to group home and auto insurance benefits through the MetPay Home and Auto Insurance Program. This program is available via payroll deduction at discounted group rates.

The MetPay benefits line is available Monday through Saturday for quotes, to apply for coverage, and customer service. Claims can be reported 24 hours a day, 7 days a week. For more information, please call MetPay directly at: 1-800-GET-MET8 (1-800-438-6388)

### Identity Theft Insurance

You may purchase identity theft coverage at competitive rates for yourself and/or your dependents through the National Small Business Travel & Health Association (NSBTHA).

This coverage provides up to $25,000 in benefits to pay for loss resulting from theft of your personal identification, Social Security number, or other method of identification, including identity theft arising out of your use of the Internet.

Full policy provisions and options are available by visiting the NSBTHA web site: www.NSBTHA.org (866-551-4722)

Even when you have identity theft coverage, it is important for you to do your part and take steps to secure your financial information while at work and in your home. The identity theft experts offer some ideas to help:

- Lock up your financial paperwork
- Password protect your computer
- Do not give anyone else your credit, debit cards, or personal information numbers (PIN) over the telephone
- Talk with your children about good credit and the effect of identity theft
- Monitor your credit card and banking accounts online, which will help to detect theft faster rather than waiting for monthly statements
- Request a free copy of your credit report annually at www.annualcreditreport.com
Over-the-Counter Drug Benefit Program

Franciscan has arranged a discount on over-the-counter (OTC) medications and nutritional supplements with Harvard Drug Group’s Major Brand. This program makes high quality non-prescription healthcare products available to you and your family at reasonable prices. For more information or to place an order:

- Call 1-800-875-0123 extension 6389 (Monday – Friday, 9 a.m. – 4 p.m. EST).
- Go to www.harvardlink.com, and complete a registration form.
- From the home page, click the link SSFHS Contract Members.
- When prompted, enter the company name: SSFHS and password: SISTERS
- Fax an order form to 1-877-562-0414.

Microsoft® Home Use Program

Franciscan employees who utilize Microsoft® Office products at work to do their job are eligible to purchase some of these same Microsoft® Office tools to install on their home PC.

Products Available
This program enables you to get a copy of most Microsoft® Office desktop applications to install and use on your home computer.

This offering includes only Microsoft® Office desktop products such as Word, Excel, PowerPoint and Access.

Eligibility
This is an exclusive discount program offered only to employees of Franciscan. To be eligible to purchase this significantly discounted software, you must:

- Be actively employed with Franciscan.
- Utilize a MS Office product as part of your job with Franciscan.
- Have a FranciscanAlliance.org email address.
- Agree to the Home Use License Agreement, including the removal of the product from your home PC upon separation of employment with Franciscan.

Cost of Microsoft® Office
The employee cost of the Microsoft® Office software through this program is currently $9.99.

Accessing the Web Site
To access and order products on the Microsoft® Home Use Program web site, please follow the steps below:

- Open the internet browser on your PC.
- Type https://hup.microsoft.com/
- Choose your preferred country and language.
- For Work Email, enter your Franciscan corporate email address (example: jane.doe@franciscanalliance.org).
- For Program Code, enter the Franciscan specific program code FB910A73DD. Note: this program code is assigned to our organization for our sole use in accessing this site. You may not share this number with anyone outside our organization.
- Place your order online, and it will be shipped to you.

Microsoft® Security Essentials Benefit Program

Franciscan employees can get a free licensed copy of the Microsoft® Security Essentials to install and use on your home computer. You may get your copy of the software by downloading it from the Microsoft® web site.

Please refer to the instructions found on the Franciscan System Intranet home page in the section for Discount Programs for more information on how to obtain your software.

Products Available
The home-use license includes the same products that you would receive if you purchased the boxed product at a retail outlet. This includes protection from viruses, malicious code, spyware, and hackers.

Eligibility
This is an exclusive program offered only to employees of Franciscan. To be eligible to obtain the free copy of this software, you must:

- Be actively employed with Franciscan.
- Agree to remove the product from your home PC upon separation of employment with Franciscan.

Cost
There is no cost to you.

A Benefit for Franciscan and You
With many employees now using their home computers to access the Franciscan network, ensuring that home computers are protected adds an additional layer of protection for the corporate network. We encourage employees to install this software on their home computers.
AT&T Wireless Employee Discount Program

Through AT&T Wireless, Franciscan employees can purchase wireless products and services at a discounted price.

Products Available
Some of the products available include cellular phones and services, wireless products such as Blackberrys and Palms, and wireless accessories.

Eligibility
All current Franciscan employees are eligible to use this discount program for their wireless purchases.

Benefit Details
The following discounts are currently available to Franciscan employees:

- 22% service discount on AT&T National Voice Plans, Data Connect Plans, and any other generally available post-paid plans service plans
- Service discount only applies to the primary line on the Family Talk Plans
- 20% equipment discount or promotional price, whichever is lower cost to employee
- 25% off all accessories or promotional price, whichever is lower cost to employee
- New activation fees waived if order is placed through web site (www.wireless.att.com/benefits/healthtrust)
- 2-Year Service Plan Agreement required
- Waived shipping fees with 2-year contract
- Free features: Voice Mail, Caller ID, Call Waiting, Call Forwarding, Detailed Billing
- Standard rate plans, devices, coverage maps, and more may be viewed at www.wireless.att.com
- Current AT&T customers may sign up for the discount without changing or extending their current contract

Accessing the Discount

Current Franciscan Discount Plan Customers

- Go to: www.wireless.att.com/benefits/healthtrust
- Select Discounts Registration under Already an AT&T Customer
- Select Online Validation Process under Existing Customers
- Enter a valid email address or follow instructions for verification form
- Enter your mobile phone number
- Enter the last four digits of your SSN

- Certify your affiliation with HealthTrust Purchasing Group

AT&T Web Site

- Go to: www.wireless.att.com/benefits/healthtrust
- During the ordering process, you will be asked to verify your employment by providing the following HPG AT&T Foundation Account Number: 02000931.
- You do not need a Franciscan email address to order via this site.

Retail Stores
You may obtain your discount at any AT&T retail location by providing the following to the retailer:

- HPG AT&T FAN number: 02000931 AND
- Your Employee ID badge or Payroll Advice

Please see FRANC for more information on this and all other Franciscan discount programs.

Verizon Wireless Employee Discount Program

Through Verizon Wireless, Franciscan employees can purchase wireless products and services at a significantly discounted price.

Products Available
Some of the products available include cellular phones, cellular phone services, wireless products such as Blackberrys and Palms, and wireless accessories.

Eligibility
All current Franciscan employees are eligible.

Benefit Details
The following discounts are currently available to Franciscan employees:

- You can register your lines for a 19% discount and receive a 3% bonus discount by enrolling in My Verizon and paperless billing. Discount applies to your Monthly Account Access Fees. Two-year line term on eligible Calling Plans $34.99 or higher is required.
- Current Verizon Customers may register their current line to obtain the Franciscan discount.
- 25% off wireless products and accessories

Accessing the Discount

Verizon Web Site

- The method is available only if you have a Franciscan company email address.
- To use this method, go to the web site: www.verizonwireless.com/discounts and enter your franciscanalliance.org email address.
On-Site Locations

• Watch for representatives to be on-site at our facilities to discuss the benefit, demonstrate products, and help you sign up for service.

Please see the Intranet for more information on this and all other Franciscan discount programs.

PC Equipment Disposal Program

Franciscan employees may dispose of up to 2 personal computers (PCs) annually through this program - at no cost. This program encourages convenient, safe disposal of these items that are hazardous to our environment.

Benefit Details

Franciscan has contracted with Cascade Asset Management to properly dispose of Franciscan owned equipment.

Equipment

Equipment that can be disposed of through this process includes: personal computer, monitor, mouse, keyboard, printer, external drive, or other hardware.

Accessing the Service

For more specifics on this program, please see the Intranet or contact Human Resources.

Other Important Information

Continuation of Coverage (COC) General Notice

You are receiving this notice because you may be covered under a Franciscan Alliance, Inc. health benefit plan (Plan). This notice contains important information about your right to Continuation of Coverage (COC), which is a temporary extension of coverage under the Plan. This notice explains COC, when it becomes available to you and your family, and what you need to do to protect the right to receive it.

COBRA or COC?

Franciscan Alliance, Inc. is committed to managing and administering all Franciscan benefit plans in accordance with applicable laws and regulations, including those established under the Employee Retirement Income Security Act (ERISA), as appropriate. ERISA is a complex law, but its basic goals are: safety of plan funds; protection of earned benefits; fairness in plan design and administration; and clear explanation of the Plan to employees. We strongly endorse these goals; and we are committed to incorporating such safeguards as those described above in all of our benefit plans.

Franciscan Alliance, Inc. medical plans, as “church plans” (as defined by Section 414 (e) in the Internal Revenue Code of 1986, as amended, and Section 3(33) of the Employee Retirement Income Security Act (ERISA) as amended) are exempt from the provisions of ERISA. Because of this exemption, Franciscan plans take full advantage of the law to provide for the best interests of its participants while still conforming to the spirit of ERISA. Since the requirements of the Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA) fall under ERISA, Franciscan plans are also exempt from COBRA’s requirements. Therefore, the right to continuation of benefits under Franciscan health plans is referred to as Continuation of Coverage (COC) as opposed to COBRA, and the terms of COC differ slightly from COBRA’s requirements.

COC can become available to you when you otherwise would lose your group medical, dental, or vision coverage. It also can become available to other members of your family who are covered under a health plan when they otherwise would lose their group health coverage. For additional information about your rights and obligations under Franciscan health plans, you should review the Plan’s summary booklet, or contact your Human Resources Department.

What is COC?

COC is a continuation of health plan coverage when coverage otherwise would end because of a life event known as a qualifying event. Specific qualifying events are listed later in this notice. Under the terms of the Plan, after a qualifying event, COC 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. Under the Plan, qualified beneficiaries who elect COC must pay for COC.

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

• your hours of employment are reduced, 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 happen:

• your spouse dies;
• your spouse’s hours of employment are reduced;
• your spouse’s employment ends for any reason other than his or her gross misconduct;
• your spouse becomes entitled to Medicare benefits under Part A, Part B, or both; or
• you become divorced or legally separated from your spouse.
Your dependent children will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happen:

- the parent-employee dies;
- the parent-employee’s hours of employment are reduced;
- the parent-employee’s employment ends for any reason other than his or her gross misconduct;
- the parent-employee becomes entitled to Medicare benefits under Part A, Part B, or both;
- the parents become divorced or legally separated; or
- the child stops being eligible under the Plan as a dependent child.

When Is COC Available?
COC is offered to qualified beneficiaries only after your Human Resources Department has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction in hours of employment, death of the employee, or the employee’s becoming entitled to Medicare benefits (under Part A, Part B, or both), the Human Resources Department Medical Benefits Specialist must notify the Plan Administrator of the qualifying event.

YOU MUST GIVE NOTICE OF SOME QUALIFYING EVENTS
For other qualifying events—divorce or legal separation of the employee and the spouse, or a dependent child’s losing eligibility for coverage as a dependent child—you must notify Human Resources within 30 days after the qualifying event occurs. You must provide this notice in writing to your local Benefits Specialist in the Human Resources Department.

Failure to notify Human Resources of a qualifying event within 30 days after the qualifying event occurs will disqualify the qualified beneficiary from COC eligibility.

How Is COC Provided?
Once Human Resources receives notice that a qualifying event has occurred, COC will be offered to each qualified beneficiary. Each qualified beneficiary has an independent right to elect COC. Covered employees can elect COC on behalf of their spouses, and parents can elect COC on behalf of their children. COC is a temporary continuation of coverage and lasts for up to 12 months. COC due to the death of the covered employee may continue up to 24 months.

Keep Human Resources Informed of Address Changes
To protect your family’s rights, you must keep your Human Resources Department informed of any changes in the addresses of family members. You also should keep for your own records a copy of any notices you send to Human Resources.

If You Have Questions
Questions concerning your COC rights should be addressed to your local Benefits Specialist in the Human Resources Department.

Children’s Health Insurance Program Reauthorization Act of 2009
On February 4, 2009, President Obama signed into law the Children’s Health Insurance Program Reauthorization Act of 2009 (“CHIPRA”). This federal legislation created a new special enrollment right under HIPAA for you and your dependents who participate in the Franciscan Alliance, Inc. medical, dental, and vision plans. It also created an additional election change event under the Franciscan Alliance, Inc. Flexible Benefit Plan. The purpose of this summary is to notify you of the new HIPAA special enrollment events created by this legislation, and your rights and notice obligations related to those events.

If you are an otherwise eligible employee and you declined to participate in the medical, dental and/or vision plans when you were first eligible or at open enrollment, you and/or your dependents may have the right to elect such coverage upon occurrence of a “special enrollment event” as provided by HIPAA. You also have the opportunity to make a corresponding change in your elections under the flexible benefit plan when a special enrollment event occurs.

HIPAA special enrollment events generally occur when you or your dependents lose coverage under another employer’s group health plan (unless due to failure to pay premiums), and when you gain a dependent through marriage, birth or adoption. You have 30 days from the occurrence of one of these events to notify Human Resources and enroll in the medical, dental, and/or vision plans, and to make a corresponding election change under the flexible benefit plan.

As of April 1, 2009, you and/or your dependents may have additional special enrollment rights if coverage is lost under Medicaid or a State Children’s Health Insurance Program (“SCHIP”), or when you and/or your dependents gain eligibility for state premium assistance. You have 60 days from the occurrence of one of these events to notify Human Resources and enroll in the medical, dental, and/or vision plans, and to make a corresponding election change under the flexible benefit plan.

If you have any questions about this summary, please contact your local Human Resources Department.
Medicare Part D

Please read this section carefully if you are Medicare eligible.

This notice has information about your prescription drug coverage available January 1, 2014. It also tells you where to find more information and help in making decisions about your prescription drug coverage.

Our plans provide prescription drug coverage under the medical plan. If you enroll in a Medicare prescription drug plan, you will not be able to purchase medical coverage separately through Franciscan. If you elect to discontinue your Franciscan provided healthcare plan, you will only be able to re-enroll in the program at the time of open enrollment or if there is a family status change.

The prescription drug coverage offered by Franciscan for the Premier 500 and Premier 1,000 plans are, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

**It is important for you to know:** If you enroll in the Premier HDHP Plan, you will be losing creditable prescription drug coverage and you will be eligible for a two (2) month special enrollment period to join a Medicare drug plan.

If you drop or lose your coverage with Franciscan and do not enroll in Medicare prescription drug coverage after your current coverage ends, you may pay more to enroll in Medicare prescription drug coverage later. If after May 15, 2006, you go 63 days or longer without prescription drug coverage that is at least as good as Medicare’s standard level prescription drug coverage, your monthly premium will go up at least 1% per month for every month after May 15, 2006 that you did not have coverage.

For example, if you go 19 months without coverage, your premium will be at least 19% higher than what most other individuals pay. You will have to pay this higher premium as long as you have Medicare coverage.

If you have questions regarding your current prescription drug coverage, contact Human Resources.

If you have questions about your options under the Medicare prescription drug coverage, contact the Indiana Health Insurance Assistance Program at 1-800-452-4800. You can also obtain additional information about Medicare prescription drug plans from the following sources:

www.medicare.gov
1-800-MEDICARE [1-800-633-4227]
TTY 1-877-486-2048

For individuals with limited income and resources, assistance in paying for a Medicare prescription drug plan is available. Information about this program option is available from the Social Security Administration (SSA).

www.socialsecurity.gov
1-800-772-1213
TTY 1-800-325-0778

Notice of Opportunity to Enroll Due to Extension of Dependent Coverage to Age 26

One provision of the Patient Protection and Affordable Care Act (PPACA) extends dependent coverage to age 26 in order to provide transitional relief for a child whose coverage ended, or who was denied coverage (or was not eligible for coverage) under a group health plan. Individuals whose coverage ends, or who were denied coverage (or were not eligible for coverage), and who have not yet reached their 26th birthday, are eligible to enroll in our health plan. This special enrollment opportunity is also extended to any employee not currently covered by the Plan who chooses to enroll in order to enable coverage for an adult dependent child, but does not extend to other non-covered family members. Employees must notify Human Resources within 30 days of the change in the dependent’s status causing the special enrollment opportunity. Coverage would then begin on the first of the month after notice of the qualifying status change is received by Human Resources. The Notice of Qualifying Event is posted on FRANC.

You may also request enrollment during the open enrollment period that begins on October 20, 2014, and ends on October 31, 2014. It is important to note that you must enroll within this time frame in order for the coverage to become effective on January 1, 2015. For more information, please contact the Human Resources Department.

New Health Insurance Marketplace Coverage Options and Your Health Coverage

PART A: General Information

When key parts of the health care law took effect in 2014, a new way to buy health insurance became available: the Health Insurance Marketplace. To assist you as you evaluate options for you and your family, this notice provides some basic information about the Marketplace and employment-based health coverage offered by your employer.
What is the Health Insurance Marketplace?
The Marketplace is designed to help you find health insurance that meets your needs and fits your budget. The Marketplace offers “one-stop shopping” to find and compare private health insurance options. You may also be eligible for a new kind of tax credit that lowers your monthly premium right away. Open enrollment for health insurance coverage through the Marketplace begins in October 2014 for coverage starting as early as January 1, 2015.

Can I Save Money on my Health Insurance Premiums in the Marketplace?
You may qualify to save money and lower your monthly premium, but only if your employer does not offer coverage, or offers coverage that doesn’t meet certain standards. The savings on your premium that you’re eligible for depends on your household income.

Does Employer Health Coverage Affect Eligibility for Premium Savings through the Marketplace?
Yes. If you have an offer of health coverage from your employer that meets certain standards, you will not be eligible for a tax credit through the Marketplace and may wish to enroll in your employer’s health plan. However, you may be eligible for a tax credit that lowers your monthly premium, or a reduction in certain cost-sharing if your employer does not offer coverage to you at all or does not offer coverage that meets certain standards. If the cost of a plan from your employer that would cover you (and not any other members of your family) is more than 9.5% of your household income for the year, or if the coverage your employer provides does not meet the “minimum value” standard set by the Affordable Care Act, you may be eligible for a tax credit.

NOTE:
If you purchase a health plan through the Marketplace instead of accepting health coverage offered by your employer, then you may lose the employer contribution (if any) to the employer-offered coverage. Also, this employer contribution - as well as your employee contribution to employer-offered coverage - is often excluded from income for Federal and State income tax purposes. Your payments for coverage through the Marketplace are made on an after-tax basis.

How Can I Get More Information?
For more information about your coverage offered by your employer, please check your summary plan description or contact Human Resources.

The Marketplace can help you evaluate your coverage options, including your eligibility for coverage through the Marketplace and its cost. Please visit HealthCare.gov for more information, including an online application for health insurance coverage and contact information for a Health Insurance Marketplace in your area.

PART B: Information About Health Coverage Offered by Your Employer

This section contains information about any health coverage offered by your employer. If you decide to complete an application for coverage in the Marketplace, you will be asked to provide this information. This information is numbered to correspond to the Marketplace application.

<table>
<thead>
<tr>
<th>3. Employer Name</th>
<th>4. Employer ID (EIN)</th>
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<tr>
<td>FRANCISCAN ALLIANCE, INC.</td>
<td>35-1330472</td>
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<tr>
<td>5. Employer Address</td>
<td>6. Employer Phone No.</td>
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<tr>
<td>1515 DRAGOON TRAIL, P.O. BOX</td>
<td>(574) 256-3935</td>
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<td>FRANCISCANALLIANCE.ORG</td>
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Here is some basic information about health coverage offered by this employer:

- As your employer, we offer a health plan to employees regularly scheduled to work at least 20 hours per week.
- We do offer coverage to your spouse and dependents as defined in the Franciscan Alliance Health Benefit Plan Document and Benefit Booklet.
- This coverage meets the minimum value standard, and the cost of this coverage to you is intended to be affordable, based on employee wages.

NOTE: Even if your employer intends your coverage to be affordable, you may still be eligible for a premium discount through the Marketplace. The Marketplace will use your household income, along with other factors, to determine whether you may be eligible for a premium discount. If, for example, your wages vary from week to week (perhaps you are an hourly employee or you work on a commission basis), if you are newly employed mid-year, or if you have other income losses, you may still qualify for a premium discount.

If you decide to shop for coverage in the Marketplace, HealthCare.gov will guide you through the process. This is the employer information you’ll enter when you visit HealthCare.gov to find out if you can get a tax credit to lower your monthly premiums.

Notice for Physician Choice

Franciscan Alliance medical plans generally require the designation of a primary care physician (PCP). You have the right to designate any primary care provider who participates in our network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider.
For information on how to select a primary care provider, and for a list of the participating primary care providers, visit www.advantageplan.com or contact Human Resources.

You do not need prior authorization from any person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in our network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the plan administrator at:

ADVANTAGE Health Solutions, Inc.
Member Services
1-888-238-8430

Women’s Health and Cancer Rights Notice

In accordance with the Women’s Health and Cancer Rights Act of 1998, a covered member who is receiving benefits for a medically necessary mastectomy and elects breast reconstruction after the mastectomy will also receive coverage for the reconstruction of the breast on which the mastectomy was performed. In addition, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of all stages of mastectomy (including lymphedema) will be covered. This coverage is subject to the same annual deductible and co-insurance provisions that apply for the mastectomy.

Newborns’ and Mothers’ Health Protection Act Notice

In accordance with the Newborns’ and Mothers’ Health Protection Act (NMHPA), health plans generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law does not prohibit the mother’s or newborn’s attending physician, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours, as applicable). In any case, plans and issuers may not, under federal law, require that a physician obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours, as applicable).

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices (“Notice”) apply to the Franciscan Alliance, Inc. Health Benefit Plan, Franciscan Alliance, Inc. Dental Benefit Plan, Eye Med Vision Care Plan and Franciscan Alliance, Inc. Flexible Benefits Plan. This Notice describes how the Plan may use and disclose your Protected Health Information (PHI) to carry out payment and health care operations, and for other purposes that are permitted or required by law.

The Plan is required to abide by the terms of this Notice so long as the Plan remains in effect. The Plan reserves the right to change the terms of this Notice as necessary and to make the new Notice effective for all PHI maintained by the Plan. Copies of revised Notices in which there has been a material change will be mailed to all participants then covered by the Plan. Copies of our current Notice may be obtained by calling the Privacy Office at the telephone number or address below.

Definitions

Plan means the Franciscan Alliance, Inc. Health Benefit Plan, Franciscan Alliance, Inc. Dental Benefit Plan, Eye Med Vision Care Plan and the Franciscan Alliance, Inc. Flexible Benefits Plan (collectively referred to as the “Plan”) and the Business Associates employed by the Plan or the Plan Sponsor who need access to your PHI to carry out their duties for the Plan.

Plan Sponsor means Franciscan Alliance, Inc. and any other employer that maintains the Plan for the benefit of its associates.

PHI means individually identifiable health information, which is defined under the law as information that is a subset of health information, including demographic information, that is created or received by the Plan and that relates to your past, present, or future physical or mental health or condition; the healthcare services you receive; or the past, present, or future payment for the health care services you receive; and that identifies you, or for which there is a reasonable basis to believe the information can be used to identify you.
Uses and Disclosures of Your Protected Health Information

The following categories describe different ways that the Plan may use and disclose your PHI. For each category of uses and disclosures we will explain what we mean and, where appropriate, provide examples for illustrative purposes. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted or required to use and disclose PHI will fall within one of the categories.

Your Authorization

Except as outlined below or otherwise permitted by law, the Plan will not use or disclose your PHI unless you have signed a form authorizing the Plan to use or disclose specific PHI for an explicit purpose to a specific person or group of persons. You have the right to revoke that authorization in writing except to the extent that the Plan has taken action in reliance upon the authorization.

Uses and Disclosures for Payment

The Plan may use and disclose your PHI as necessary for benefit payment purposes without obtaining an authorization from you. The persons to whom the Plan may disclose your PHI for payment purposes include your healthcare providers that are billing for or requesting a prior authorization for their services and treatments of you, other health plans providing benefits to you, and your approved family member or guardian who is responsible for amounts, such as deductibles and co-insurance, not covered by the Plan.

For example, the Plan may use or disclose your PHI, including information about any medical procedures and treatments you have received, are receiving, or will receive, to your doctor, your spouse’s or other health plan under which you are covered, and your spouse or other family members, unless you object, in order to process your benefits under the Plan. Examples of other payment activities include determinations of your eligibility or coverage under the Plan, annual premium calculations based on health status and demographic characteristics of persons covered under the Plan, billing, claims management, reinsurance claims, review of health care services with respect to medical necessity, utilization review activities, and disclosures to consumer reporting agencies.

Uses and Disclosures for Healthcare Operations

The Plan may use and disclose your PHI as necessary for healthcare operations without obtaining an authorization from you. Healthcare operations are those functions of the Plan it needs to operate on a day-to-day basis and those activities that help it to evaluate its performance. Examples of healthcare operations include underwriting, premium rating or other activities relating to the creation, amendment or termination of the Plan, and obtaining reinsurance coverage. Other functions considered to be healthcare operations include business planning and development; conducting or arranging for quality assessment and improvement activities, medical review, and legal services and auditing functions; and performing business management and general administrative duties of the Plan, including the provision of customer services to you and your covered dependents.

Use or Disclosure of Genetic Information Prohibited.

The Genetic Information Nondiscrimination Act of 2009 (GINA), and regulations promulgated thereunder, specifically prohibit the use, disclosure or request of PHI that is genetic information for underwriting purposes. Genetic information is defined as (1) your genetic tests; (2) genetic tests of your family member; (3) family medical history, or (4) any request of or receipt by you or your family members of genetic services. This means that your genetic information cannot be used for enrollment, continued eligibility, computation of premiums, or other activities related to underwriting, even if those activities are for purposes of healthcare operations or being performed pursuant to your written authorization.

Family and Friends Involved in Your Care

If you are available and do not object, the Plan may disclose your PHI to your family, friends, and others who are involved in your care or payment of a claim. If you are unavailable or incapacitated and the Plan determines that a limited disclosure is in your best interest, the Plan may share limited PHI with such individuals. For example, the Plan may use its professional judgment to disclose PHI to your spouse concerning the processing of a claim. If you do not wish us to share PHI with your spouse or others, you may exercise your right to request a restriction on our disclosures of your PHI (see below), including having correspondence the Plan sends to you mailed to an alternative address. The Plan is also required to abide by certain state laws that are more stringent than the HIPAA Privacy Standards; for example, Indiana gives your minor child the rights to consent to his or her own treatment and, under HIPAA, to direct who may know about the care he or she receives. There may be an instance when your minor child would request for you not to be informed of his or her treatment, and the Plan would be required to honor that request.

Business Associates

Certain aspects and components of the Plan’s services are performed through contracts with outside persons or organizations. Examples of these outside persons and organizations include our third party administrator, reinsurance carrier, agents, attorneys, accountants, banks, and consultants. At times it may be necessary for us to provide certain of your PHI to one or more of these outside persons or organizations. However, if the Plan does provide your PHI to any or all of these outside persons or organizations, they will be required, through contract or by law, to follow the same policies and procedures with your PHI as detailed in this Notice or to issue their own Notice of Policies and Procedures detailing their uses and disclosures of your PHI.
Plan Sponsor

The Plan may disclose a subset of your PHI, called summary health information, to the Plan Sponsor in certain situations. Summary health information summarizes claims history, claims expenses, and types of claims experienced by individuals under the Plan, but all information that could effectively identify whose claims history has been summarized has been removed. Summary health information may be given to the Plan Sponsor when requested for the purposes of obtaining premium bids, for providing coverage under the Plan, or for modifying, amending or terminating the Plan. The Plan may also disclose to the Plan Sponsor whether you are enrolled in or have disenrolled from the Plan.

Other Products and Services

The Plan may contact you to provide information about other health-related products and services that may be of interest to you without obtaining your authorization. For example, the Plan may use and disclose your PHI for the purpose of communicating to you about health benefit products or services that could enhance or substitute for existing coverage under the Plan, such as long term health benefits or flexible spending accounts. The Plan may also contact you about health-related products and services, like disease management programs that may add value to you, as a covered person under the Plan. However, the Plan must obtain your authorization before the Plan sends you information regarding non-health related products or services, such as information concerning movie passes, life insurance products, or other discounts or services offered to the general public at large.

Other Uses and Disclosures

Unless otherwise prohibited by law, the Plan may make certain other uses and disclosures of your PHI without your authorization, including the following:

- The Plan may use or disclose your PHI to the extent that the use or disclosure is required by law.
- The Plan may disclose your PHI to the proper authorities if the Plan suspects child abuse or neglect; the Plan may also disclose your PHI if we believe you to be a victim of abuse, neglect, or domestic violence.
- The Plan may disclose your PHI if authorized by law to a government oversight agency (e.g., a state insurance department) conducting audits, investigations, or civil or criminal proceedings.
- The Plan may disclose your PHI in response to a court order specifically authorizing the disclosure, or in the course of a judicial or administrative proceeding (e.g., to respond to a subpoena or discovery request), provided written and documented efforts by the requesting party have been made to (1) notify you of the disclosure and the purpose of the litigation, or (2) obtain a qualified protective order prohibiting the use or disclosure of your PHI for any other purpose than the litigation or proceeding for which it was requested.
- The Plan may disclose your PHI to the proper authorities for law enforcement purposes, including the disclosure of certain identifying information requested by police officers for the purpose of identifying or locating a suspect, fugitive, material witness or missing person; the disclosure of your PHI if you are suspected to be a victim of a crime and you are incapacitated; or if you are suspected of committing a crime on the Plan (e.g., fraud).
- The Plan may use or disclose PHI to avert a serious threat to health or safety.
- The Plan may use or disclose your PHI if you are a member of the military, as required by armed forces services, and the Plan may also disclose your PHI for other specialized government functions such as national security or intelligence activities.
- The Plan may disclose your PHI to state or federal workers’ compensation agencies for your workers’ compensation benefit determination.
- The plan may, as required by law, release your PHI to the Secretary of the Department of Health and Human Services for enforcement of the HIPAA Privacy Rules.

Verification Requirements

Before the Plan discloses your PHI to anyone requesting it, the Plan is required to verify the identity of the requester and the requester’s authority to access your PHI. The Plan may rely on reasonable evidence of authority such as a badge, official credentials, written statements on appropriate government letterhead, written or oral statements of legal authority, warrants, subpoenas, or court orders.

Rights that You Have

To request to inspect, copy, amend, or get an accounting of PHI pertaining to your PHI in the Plan, you may contact the Privacy Officer at Franciscan Alliance, Inc., 1515 Dragoon Trail, P.O. Box 1290, Mishawaka, Indiana 46546-1290; (574) 256-3935.

Right to Inspect and Copy Your PHI

You have the right to request a copy of and/or inspect your PHI that the Plan maintains, unless the PHI was compiled in reasonable anticipation of litigation or contains psychotherapy notes. In certain limited circumstances, the Plan may deny your request to copy and/or inspect your PHI. In most of those limited circumstances, a licensed healthcare provider must determine that the release of the PHI to you or a person authorized by you, as your “personal representative,” may cause you or someone else identified in the PHI harm. If your request is denied, you may have the right to have the denial reviewed by a designated licensed healthcare professional that did not participate in the original decision. Requests for access to your PHI must be in writing and signed by you or your personal representative. You may ask for a Participant PHI Inspection Form from the Plan through the Privacy Office at the address below. If you request that the Plan copy or mail your PHI to you, the Plan may charge you a fee for
the cost of copying your PHI and the postage for mailing your PHI to you. If you ask the Plan to prepare a summary of the PHI, and the Plan agrees to provide that explanation, the Plan may also charge you for the cost associated with the preparation of the summary.

**Right to Request Amendments to Your PHI**

You have the right to request that PHI the Plan maintains about you be amended or corrected. The Plan is not obligated to make requested amendments to PHI that is not created by the Plan, not maintained by the Plan, not available for inspection, or that is accurate and complete. The Plan will give each request careful consideration. To be considered, your amendment request must be in writing, must be signed by you or your personal representative, must state the reasons for the amendment request, and must be sent to the Privacy Office at the address below. If the Plan denies your amendment request, the Plan will provide you with its basis for the denial, advise you of your right to prepare a statement of disagreement which it will place with your PHI, and describe how you may file a complaint with the Plan or the Secretary of the US Department of Health and Human Services. The Plan may limit the length of your statement of disagreement and submit its own rebuttal to accompany your statement of disagreement. If the Plan accepts your amendment request, it must make a reasonable effort to provide the amendment to persons you identify as needing the amendment or persons it believes would rely on your unamended PHI to your detriment.

**Right to Request an Accounting for Disclosures of Your Protected Health Information**

You have the right to request an accounting of disclosures of your PHI that the Plan makes. Your request for an accounting of disclosures must state a time period that may not be longer than six years and may not include dates before April 14, 2004. Not all disclosures of your PHI must be included in the accounting of the disclosures. Examples of disclosures that the Plan is required to account for include those pursuant to valid legal process, or for law enforcement purposes. Examples of disclosures that are not subject to an accounting include those made to carry out the Plan’s payment or health care operations, or those made with your authorization. To be considered, your accounting requests must be in writing and signed by you or your personal representative, and sent to the Privacy Office at the address below. The first accounting in any 12-month period is free; however, the Plan may charge you a fee for each subsequent accounting you request within the same 12-month period.

**Right to Place Restrictions on the Use and Disclosure of Your Protected Health Information**

You have the right to request restrictions on certain of the Plan’s uses and disclosures of your PHI for payment or healthcare operations, disclosures made to persons involved in your care, and disclosures for disaster relief purposes. For example, you may request that the Plan not disclose your PHI to your spouse. Your request must describe in detail the restriction you are requesting. The Plan is not required to agree to your request, but will attempt to accommodate reasonable requests when appropriate. The Plan retains the right to terminate an agreed-to restriction if it believes such termination is appropriate. In the event of a termination by the Plan, it will notify you of the termination. You also have the right to terminate, in writing or orally, any agreed-to restriction. Requests for a restriction (or termination of an existing restriction) may be made by contacting the Plan through the Privacy Office at the telephone number or address below.

**Request for Confidential Communications**

You have the right to request that communications regarding your PHI be made by alternative means or at alternative locations. For example, you may request that messages not be left on voice mail or sent to a particular address. The Plan is required to accommodate reasonable requests if you inform the Plan that disclosure of all or part of your information could place you in danger. The Plan may grant other requests for confidential communications in its sole discretion. Requests for confidential communications must be in writing, signed by you or your personal representative, and sent to the Privacy Office at the address below.

**Right to a Copy of the Notice**

You have the right to a paper copy of this Notice upon request by contacting the Privacy Office at the telephone number or address below.

**Complaints**

If you believe your privacy rights have been violated, you can file a complaint with the Plan through the Privacy Office in writing at the address below. You may also file a complaint in writing with the Secretary of the U.S. Department of Health and Human Services in Washington, D.C., within 180 days of a violation of your rights. There will be no retaliation for filing a complaint.

**For Further Information**

If you have questions or need further assistance regarding this Notice, you may contact our Privacy Office by writing to:

**FRANCISCAN ALLIANCE**

**Privacy Office**

c/o Senior VP of Administrative Services

1515 Dragoon Trail

P.O. Box 1290

Mishawaka, Indiana 46546-1290

(574) 256-3935
Benefits Glossary

Benefit Terms

Before-tax
Payment for benefits that is deducted from your paycheck before your income has been taxed by the IRS.

Beneficiary
With respect to an insurance plan, a person named, in writing, by a covered employee to receive benefits in the event of the employee’s death.

Brand Name Drug
Patented drug sold under a trade name.

Brand Name Formulary Drug
A brand name drug that is currently part of the formulary.

Brand Name Non-Formulary Drug
A brand name drug that is not part of the formulary and is subject to a higher co-payment.

Co-payment / Co-pay
A cost sharing arrangement in which a covered person pays a specified charge for a specified service, such as $15 for an office visit. The covered person is usually responsible for payment at the time the health care is rendered. Typical co-payments are fixed or variable flat amounts for physician office visits, prescriptions or hospital services.

Co-insurance
Percent you pay for covered services after the deductible has been met.

Coordination of Benefits
Provision designed to prevent duplication of benefits for the same expense under more than one benefit plan.

When the Franciscan plan is primary, the plan makes the normal payment. If there are expenses remaining, they may be submitted to the secondary carrier to cover any costs that may be allowed under the second plan. When the Franciscan plan is secondary (such as for a spouse), the combined payment made by both plans cannot exceed the greater of the Franciscan maximum plan payment in absence of other coverage, or the payment made by the primary plan, if that plan’s payment is greater than the Franciscan plan.

Deductible
The amount you pay up front before the plan starts paying for covered services.

Family Status Change
Changes to your benefit elections are only allowed when one of the conditions below applies. Change requests must be made within 30 days of the date of the family status change.

Family status change includes marriage, divorce, legal separation, annulment, birth or adoption of a child, significant change in the health coverage of the employee or spouse attributable to the spouse’s employment, commencement or termination of spouse’s employment, death of spouse or child, loss or reinstatement of dependent eligibility, switch from part-time to full-time employment (or vice versa) by the employee or spouse, commencement or return from a leave of absence granted under the Family and Medical Leave Act or unpaid leave, entitlement to Medicare or Medicaid, judgment decree or court order and change of residence or worksite.

Formulary Drug
A list of commonly prescribed drugs that will be covered by the plan with a lower co-payment.

Generic Drug
Non-patented drug sold under its technical name and not a trade name.

Generic Formulary Drug
Non-patented drug that is part of the formulary.

HDHP (High Deductible Health Plan)
A health insurance plan with lower premiums and higher deductibles than a traditional plan.

HMO
Health Management Organization

HSA (Health Savings Account)
An account created for individuals who are covered under a high deductible health plan (HDHP) to save for medical expenses than an HDHP doesn’t cover.

In-Network
The selection of services or service providers within a network. Providers within the network have agreed to discount their services and accept reimbursement at usual and customary rates or at a predetermined (discounted) fee.

Lifetime Maximum Benefit
Lifetime maximum amount that the plan will pay for each covered person.

Out-of-Pocket Maximum
The maximum amount you pay in a plan year for covered medical expenses, excluding your medical deductible.
PCP
Primary Care Physician

Plan Year
January 1 through December 31 of a given year. If you were hired after January 1, the plan year runs from the first of the month in which your coverage begins through December 31 of the same year.

Year of Service
A year of service in the retirement program is a plan year in which you are credited with at least 1,000 hours. The plan year for the retirement program is January 1 - December 31.

A Year of Service for other benefit purposes is generally based on your last date of hire. Each benefit plan’s definition of a year of service will determine eligibility.

This Booklet is a Summary

This summary is provided as a general guide to assist you in understanding and using your benefits. Plan details, limitations, and exclusions can be found in the plan documents that are available from Human Resources or on FRANC. In the event a discrepancy exists between the plan documents and any information summarized here, oral communications, descriptions, or explanations of the benefits under any plan, the official plan documents will prevail.

Franciscan reserves the right to change or end any of the benefit plans, at any time and for any reason, to the extent allowed by law.

Your participation in these plans is not a contract of employment and does not guarantee future employment with Franciscan.
Corporate Office
Coordinated Business Office
Ambulatory Business Office
Central Order Verification Pharmacy
Information Services
Franciscan St. Anthony Health - Michigan City
Franciscan St. Anthony Health - Crown Point
Franciscan St. Margaret Health - Hammond
Franciscan St. Margaret Health - Dyer
Franciscan OMNI Health & Fitness
Franciscan Healthcare - Munster
Franciscan St. Elizabeth Health
Franciscan Physician Network

Franciscan ALLIANCE

10/2014