



SmartHealth

A Medical Plan
Provided Exclusively For Associates
of the
Michigan Health Ministries of Ascension Health

Plan Document



Effective January 1, 2010

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ARTICLE 1—DEFINITIONS

Certain words and/or phrases that are used and capitalized throughout this Plan document are defined and explained below. These definitions and/or explanations shall control with respect to the interpretation of the Plan.

Feminine pronouns used shall include masculine or feminine gender unless the context indicates otherwise.

1.1 "Accredited Care Facility" means for:

Substance Abuse--A facility licensed, certified, or approved as a treatment facility by the state or jurisdiction in which it operates, operating primarily for treatment of Substance Abuse conditions which maintains permanent and full-time facilities for bed care and full time confinement of at least 15 patients; has a Physician in regular attendance; provides 24 hour per day nursing by a registered nurse; and has a full-time psychiatrist or psychologist on the staff.

Psychiatric Services--A facility licensed, certified, or approved as a Psychiatric Treatment facility by the state or jurisdiction in which it is located, and which primarily provides psychiatric services for the diagnosis and treatment of mentally ill persons, by or under the supervision of a Physician.

1.2 "Ambulatory Care Center" means a specialized facility:

- A. where coverage in such facility is mandated by law, has been licensed by the regulatory authority having responsibility for such licensing under the laws of the jurisdiction in which it is located; or
- B. where coverage in such facility is not mandated by law, meets all of the following requirements:
 - 1. it is established, equipped, and operated in accordance with the applicable laws in the jurisdiction in which it is located primarily for the purpose of performing Surgical Procedures; and
 - 2. it is operated under the supervision of a licensed Doctor of Medicine (M.D.) or a Doctor of Osteopathy (D.O.) who is devoting full-time to such supervision and permits a Surgical Procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform such procedure in at least one Hospital in the area; and
 - 3. it requires in all cases, other than those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetics and remain present throughout the Surgical Procedure; and
 - 4. it provides at least two operating rooms and at least one post-anesthesia recovery room; to be equipped to perform diagnostic x-ray and laboratory examinations; and has available, to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to a defibrillator, a tracheotomy set, and a blood bank or other blood supply; and

5. it provides the full-time services of one or more registered nurses for patient care in the operating rooms and in the post-anesthesia recovery room; and
 6. it maintains a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications or require postoperative confinement; and
 7. it maintains an adequate medical record for each patient, such record to contain an admitting diagnosis, including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays, an operative report, and a discharge summary.
- 1.3 "Annual Out-of-Pocket Maximum" means the maximum of Covered Expenses withheld, after the Deductible has been paid, because of the Copayment provisions for charges incurred in any calendar year by the Covered Person.
 - 1.4 "Balance Billing" means billing a Covered Person for the difference between the reimbursement allowed by the Plan and the charges billed by a non-participating provider, (that is, a provider that is not a Tier 1 or Tier 2 Network provider).
 - 1.5 "Birthing Center" means a facility operated by a Hospital or other licensed health care institution for the purposes of providing facilities for childbirth as an alternative to the environment of the Hospital delivery room.
 - 1.6 "Child" means a dependent as defined in Section 5.2.B.
 - 1.7 "Claims Administrator" means the entity or individual that is responsible for determining a claim. This reference applies to the Plan Administrator or a third party hired by the Plan Administrator and designated in writing to be a fiduciary. For Pre-Service, Concurrent Care, and Time-Sensitive Claims, the Claims Administrator is the Managed Care Representative selected by the Plan Administrator. For Post-Service Claims, the Claims Administrator shall be the third party hired by the Plan Administrator or other entity or individual designated in writing to be a fiduciary.
 - 1.8 "Community Blue Provider" means a provider other than the Michigan Health Ministries of Ascension Health (as listed in Section 1.42) that has contracted with Blue Cross Blue Shield of Michigan (BCBSM) and is listed as BCBSM's Community Blue/Blue Preferred PPO Network (or is a Blue Card provider outside of Michigan).
 - 1.9 "Co-Pay" means a service specific flat dollar amount payable by a Covered Person at the place and time services are rendered.
 - 1.10 "Copayment" means the sharing of the cost of Covered Expenses between the Plan and the Covered Person. When the Plan pays a percentage of the Reasonable and Customary Charge or the Preferred Provider allowable amount, the Copayment equals the Covered Person's balance.
 - 1.11 "Cosmetic Surgery" means reconstructive or plastic surgery which is done primarily to improve the physical appearance of the patient and which improves the physical appearance but does not correct or improve a medical condition.

- 1.12 "Covered Expenses" means the costs incurred with respect to the services, supplies, and charges for which benefits are provided in this Plan, and as more specifically defined in the provisions of the Plan relating to coverage.
- 1.13 "Covered Person" means an Eligible Employee (or other person as specified in the Addendum) and/or an Eligible Dependent who participates under *SmartHealth* as defined in Article 5 – Eligibility and Article 6 – Participation.
- 1.14 "Custodial Care" means care given mainly to help a person with daily living activities, and not primarily given to assist such person in recovering from an Injury or Illness. This type of care will be considered custodial regardless of whether or not the patient is under a Physician's care and/or the Custodial Care is requested by the Physician.
- 1.15 "Deductible" means the amount of Covered Expenses that an individual and/or family must satisfy before being eligible for certain benefits to be payable by the Plan.
- 1.16 "Dentist" means a person duly licensed to practice dentistry by the governmental authority having jurisdiction over the licensing and practice of dentistry in the locality where the service is rendered.
- 1.17 "DME" means durable medical equipment and supplies.
- 1.18 "Emergency Dental Treatment" means dental care necessary because of a condition that is life-threatening, or threatening to the vitality of a tooth or teeth, that has a sudden onset and demands prompt attention.
- 1.19 "Emergency Medical" means severe symptoms which occur suddenly and unexpectedly, and if treatment is not rendered within the first 48 hours of onset, could cause serious harm to bodily functions or even death.
- 1.20 "Eligible Dependent" means family members who are dependent on an Eligible Employee as defined in Section 5.2.
- 1.21 "Eligible Employee" means an associate who renders services for which she is entitled to remuneration from a Participating Employer, other than an independent contractor, and who meets the eligibility requirements set forth in Article 5 and Addendum 1.
- 1.22 "Expenses Incurred" means a charge, which shall be deemed to be incurred on the day the purchase is made, or on the day the service is rendered for which a charge is made.
- 1.23 "Experimental Treatment" means a service, supply or treatment that is deemed experimental or investigational by the Plan Administrator. The decision of the Plan Administrator is not intended to be and is not a determination of the medical appropriateness of the treatment but is a determination of the scope of Plan coverage.
- 1.24 "Extended Care Facility" means an institution (or a distinct part of an institution) which:
- A. is primarily engaged in providing for Inpatient, skilled nursing care and related services for patients who require medical or nursing care, or rehabilitation service for the rehabilitation of injured or sick persons;

- B. has policies, which are developed with the advice of (and with provision for review of such policies from time to time by) a group of professional personnel, including one or more Physicians and one or more registered nurses, to govern the skilled nursing care and related medical or other services it provides;
- C. has a Physician, a registered nurse, or a medical staff responsible for the execution of such policies;
- D. has a requirement that the health care of every patient must be under the supervision of a Physician, and provides for having a Physician available to furnish necessary medical care in case of emergency;
- E. maintains clinical records on all patients;
- F. provides 24-hour nursing care in accordance with the policies developed as provided in subparagraph (b) above, and has at least one registered nurse employed full-time;
- G. provides appropriate methods and procedures for dispensing and administering drugs and biologicals;
- H. has in effect a utilization review plan which provides for the review, on a sample or other basis, of admissions to the institution, the duration of stays, and the professional services (including drugs and biologicals) furnished with respect to the Medical Necessity of the services, and for the purpose of promoting the most efficient use of available health facilities and services and with such review to be made by either a staff committee of the institution composed of two or more Physicians, with or without participation of other professional personnel, or a group similarly composed which is established by the local medical society and some or all of the Hospitals and Extended Care Facilities in the locality. Such review provides for prompt notification to the facility, the individual, and the attending Physician of a finding that further stay in the facility is not Reasonably Necessary;
- I. is licensed pursuant to an applicable state or local law or is approved by the appropriate state or local agency for such licensing, except that such term shall not include any institution which is primarily used for Custodial Care.

1.25 "Home Health Agency" means a public agency or private organization, or a subdivision of such an agency or organization, that is:

- A. primarily engaged in providing skilled nursing services and other therapeutic services;
- B. has policies established by a group of professional personnel employed with the agency or organization, including one or more legally qualified Physicians and one or more registered nurses;
- C. maintains clinical records on all patients; and, in the case of an agency or organization in any state in which state or applicable local law provides for licensing of agencies or organizations of this nature;

- D. is licensed pursuant to such law or is approved by the agency of such state or locality responsible for licensing agencies or organizations of this nature, as meeting the standards established for such licensing.

In no event, however, shall the term "Home Health Agency" include any agency or organization or subdivision which is engaged primarily in the care and treatment of a mental disease.

- 1.26 "Home Ministry" means the Michigan Health Ministry of Ascension Health through which the Covered Person is enrolled in *SmartHealth*.
- 1.27 "Hospice Care Program" means a program that is organized and licensed as such by the state in which it is headquartered. If accreditation is available, the program must have been currently accredited. In the event that state laws or regulations do not exist with respect to Hospice Care Programs, the program must be accredited by a national accrediting organization or be recognized as a Hospice Care Program or a demonstration Hospice Care Program by the U.S. Department of Health and Human Services.
- 1.28 "Hospital" means a legally constituted Inpatient institution or Inpatient facility that meets all of the following requirements in either A or B:
- A.
1. it is an institution which is licensed and accredited as such by duly constituted state or national medical or Hospital authorities; and
 2. it is open at all times; and
 3. it provides diagnostic and therapeutic services and organized facilities for major surgery on the premises for surgical and/or medical treatment of Ill or Injured individuals; and
 4. the treatment is by or under the direct supervision of a licensed Physician or surgeon; and
 5. the facility continuously provides 24-hour nursing services by registered nurses; and
 6. it is not, other than incidentally, a place for rest, convalescent care, care for the aged, care for pulmonary tuberculosis, or a nursing home.
- B. it is a psychiatric, Substance Abuse or tuberculosis facility, state-licensed or recognized by the appropriate regulatory authority to provide treatment primarily for mental or nervous conditions, Substance Abuse care, or tuberculosis.
- 1.29 "Hospital Charges" means the following Covered Expenses:
- A. charges made by a Hospital for room and board, and charges made by the Hospital for other Hospital services and supplies furnished to a Covered Person, as the case may be, for her use while she is confined therein (but not including charges for special nursing services or services of Physicians);

- B. charges for anesthetics and its administration when incurred during a Hospital Confinement.
- 1.30 "Hospital Confinement" or "Hospital Confined" means that a person is deemed to be confined in a Hospital, for purposes of this Plan, if her confinement continues for more than 23 consecutive hours or longer and if a room and board charge is made in connection with her confinement; or if the confinement is required because of a Surgical Procedure.
- 1.31 "Hospital Observation Stay" means that a person is deemed to be incurring a Hospital Observation Stay, for purposes of this Plan, if her observation confinement continues for a period of 23 consecutive hours or less and if an observation room charge is made in connection with her Hospital Observation Stay.
- 1.32 "Illness" means a sickness or disease including mental infirmity, as classified in the International Classification of Diseases (ICD-9) and which requires treatment by a Physician. For purposes of determining benefits payable, "Illness" shall include Pregnancy. All related Illnesses shall be considered one Illness. Concurrent Illnesses shall also be considered one Illness unless such Illnesses are clearly unrelated.
- 1.33 "Injury" means bodily Injury sustained accidentally by external means, including such Illness as results from an accident. All Injuries sustained by a Covered Person in connection with any accident shall be considered one Injury.
- 1.34 "Inpatient" means a person who is Hospital Confined.
- 1.35 "Intensive Care Unit" means a special unit in a Hospital concentrating all necessary types of equipment together with skilled nursing.
- 1.36 "Joinder Agreement" means the form prescribed by the Plan Administrator pursuant to which a Participating Employer adopts the Plan, as provided in Section 14.15.
- 1.37 "Lifetime" means the period of time a Covered Person is covered under the Plan.
- 1.38 "Lifetime Coverage Maximum" means the maximum amount payable for each Covered Person during their Lifetime, as stated in the Schedule of Medical Benefits.
- 1.39 "Managed Care Representative" means the entity or individual chosen by the Plan Administrator to review medical claims to determine if requested services are Reasonably Necessary.
- 1.40 "Medical Charges" means Covered Expenses which are not Hospital charges or Surgical Charges.
- 1.41 "Medicare" means the programs established by Title 1 of Public Law 89-97 (79 Statutes 291), as amended, entitled Health Insurance for the Aged Act, and which includes Part A--Hospital Insurance Benefits for the Aged, and Part B--Supplementary Medical Insurance Benefits for the Aged.

- 1.42 "Michigan Health Ministries of Ascension Health" means the following ministries that are recognized as Tier 1 Ascension Health Michigan Network providers within the *SmartHealth* Network:
- St. John Health System, 28000 Dequindre, Warren, MI 48092-2468
 - Genesys Health System, One Genesys Parkway, Grand Blanc, MI 48439-8065
 - Borgess Health, 1521 Gull Road, Kalamazoo, MI 49048-1640
 - St. Mary's of Michigan, 800 S. Washington Avenue, Saginaw, MI 48601-2551; and St. Mary's of Michigan Standish Hospital, 805 West Cedar St., Standish, MI 48658-9526
 - St. Joseph Health System, 200 Hemlock, Tawas City, MI 48764-0659

The term also includes wholly-owned subsidiaries of these providers. While the Plan offers the flexibility of obtaining services outside of this Network, these Tier 1 providers are included with the objective of providing members with access to low cost, high quality, health services within Michigan.

- 1.43 "Network" means the *SmartHealth* network which consists of those facilities and Physicians that have contracted with the Plan Administrator to participate in *SmartHealth*. There are two classes or tiers of provider participation:
- A. Tier 1 providers are those facilities wholly, or in part, sponsored by the Michigan Health Ministries of Ascension Health and the Physicians affiliated with them. Physicians included in Tier 1 shall have contracted with *SmartHealth* either individually or through their Provider Health Organization.
- B. Tier 2 facilities or Physicians are those providers that are not Tier 1 providers but are listed as a Community Blue/Blue Preferred PPO Network providers (or are Blue Card providers outside of Michigan).
- 1.44 "Non-occupational" means, with respect to Injury, an Injury which does not arise out of and in the course of any employment for wage or profit; and, with respect to Illness, shall mean a disease in connection with which the person is entitled to no benefits under any Workers' Compensation law or similar legislation.
- 1.45 "Outpatient" means treatment at a Hospital to a person who is not Hospital Confined; or treatment rendered in a Physician's office, laboratory, x-ray facility, Ambulatory Care Center, and/or Emergency Center.
- 1.46 "Participating Employer" means a Michigan Health Ministry of Ascension Health that has agreed to participate in *SmartHealth* as provided in Section 14.15.
- 1.47 "Physician" means a medical practitioner who is licensed and legally qualified to prescribe and administer all drugs and to perform all Surgical Procedures, or a licensed Dentist practicing within the terms of her license, or a psychologist practicing in conformity with applicable laws, or any other licensed or certified practitioner of the healing arts in a category specifically favored under the health insurance laws in the state where the license or certification was issued, practicing within the terms of her license or certification.
- 1.48 "Plan" means the *SmartHealth* plan described herein, known as *SmartHealth*, and as may be amended from time to time.

- 1.49 "Plan Administrator" means the Plan Sponsor. The Plan Administrator has primary responsibility for the administration of the Plan.
- 1.50 "Plan Manager" shall mean the company providing services to the Participating Employers in connection with the operation of the Plan and performing such other functions, including processing and payment of claims, as may be delegated to it. The Plan Manager is Automated Benefit Services, Inc., 8220 Irving Road, Sterling Heights, Michigan, 48312, telephone 586-826-4300. The Plan Manager does not insure any benefit expenses of individuals covered by the Plan. Complete and proper claims for benefits made by individuals covered by the Plan will be promptly processed by the Plan Manager; but, in the event there are delays in processing claims, the individuals covered by the Plan shall have no greater rights to interest or other remedies against the Plan Manager than otherwise afforded them by the law.
- 1.51 "Plan Sponsor" shall mean St. John Health System. The Plan Sponsor shall fairly and equitably represent the interests of all Michigan Health Ministries of Ascension Health.
- 1.52 "P&O" means prosthetics and orthotics.
- 1.53 "Pregnancy" means miscarriage, or childbirth, or any complications of childbirth.
- 1.54 "Prior Authorization" means prior approval by the Managed Care Representative of elective services to be performed on a Covered Person to determine if requested services are Reasonably Necessary.
- 1.55 "Provider Directory" means Directory of Tier 1 network of providers, (which includes Physicians, Hospitals, ancillary services and selected Tier 2 providers for which Tier 1 benefits are available), available at www.SmartHealth-MI.org by searching under Provider Directory and Facility/Other Services.
- 1.56 "Psychiatric Treatment" means treatment care for a mental disease or disorder or a functional nervous disorder.
- 1.57 "Reasonable and Customary Charge" A charge shall be considered Reasonable and Customary to the extent that it does not exceed the general level of charges accepted by others of similar standing in the area where the charge is incurred, when furnishing like or comparable treatment, services or supplies to an individual of the same sex and of comparable age and income, for similar Illness or Injury. The term "area" means a county or such greater area as is necessary to establish a representative cross section of persons or other entities regularly furnishing the type of treatment, services, or supplies for which the charge was made. All determinations of "Reasonable and Customary" will be made by the Plan Administrator.
- 1.58 "Reasonably Necessary" means that recommended or prescribed care, treatment or services determined by the Plan Administrator to be covered under the Medical Program are:
- A. consistent with the documented medical condition; and
 - B. appropriate and necessary for the medical condition; and
 - C. medically proven to be effective treatment for the medical condition; and

- D. within the standards of good and accepted medical practice within the established medical community; and
- E. not primarily for the convenience of the Covered Person, the Covered Person's Physician or another health care provider; and
- F. not conducted for research purposes; and
- G. the most appropriate level of services that can be provided safely.

In furtherance of the foregoing and without limitation, for acute Inpatient care this shall mean that the care is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's medical condition, and that safe and adequate care cannot be received as an Outpatient or in a less-intensive setting.

The decision of the Plan Administrator is not intended to influence or alter the treating provider's medical judgment.

All determinations of what constitutes "Reasonably Necessary" shall be made in accordance with the policies and procedures established by the Plan Administrator and applied by the Managed Care Representative chosen by the Plan Administrator.

- 1.59 "Semi-Private Room and Board" means a 2-bed room accommodation.
- 1.60 "SmartHealth Network" See definition of Network.
- 1.61 "Sound Natural Tooth" or "Sound Natural Teeth" means a natural tooth which is in good health and function or has been restored to good health and function by professionally acceptable treatment.
- 1.62 "Substance Abuse" means the taking of alcohol or other drugs at dosages that place an individual's social, economic, psychological, and physical welfare in potential hazard. "Substance Abuse" shall also be understood to apply to an individual who loses the power of self-control as a result of the use of alcohol or drugs, or while habitually under the influence of alcohol or drugs, endangers public health, morals, safety, or welfare.
- 1.63 "Surgical Charges" means the Covered Expenses incurred for the professional services of the operating Physician in performing a Surgical Procedure or procedures on a Covered Person, including usual, necessary, and related preoperative and postoperative treatment in connection with the Surgical Procedure.
- 1.64 "Surgical Procedure" means the following:
 - A. an incision, excision, or electrocauterization of any organ or part of the body;
 - B. suturing of a wound;
 - C. the manipulative reduction of a fracture or dislocation;
 - D. radiotherapy (excluding radioactive isotope therapy) or ultrasound therapy if used in lieu of a cutting operation for removal of a tumor;

- E. endoscopic procedures;
 - F. normal delivery;
 - G. injection treatment for hemorrhoids, varicose veins, or spinal disorders.
- 1.65 “Tier 1” means the Network class as defined in Section 1.43.A.
- 1.66 “Tier 2” means the Network class as defined in Section 1.43.B.
- 1.67 “Urgent Care Facility” means a specialized facility or institution which may be freestanding or a distinct part of another facility or institution which is dedicated to the treatment of Urgent Care Medical Problems.
- 1.68 “Urgent Care Medical Problem” means an unexpected episode of Illness or an Injury requiring treatment which cannot reasonably be postponed for regularly scheduled care, but which is not life threatening, and does not require use of or treatment at an emergency room of a Hospital. Urgent Care Medical Problems include, but are not limited to, earache, sore throat, and fever (not above 104 degrees).

ARTICLE 2—MEDICAL BENEFITS

- 2.1 “Medical Coverage Provided” The coverages becoming effective on the Plan Effective Date are only those shown in the Schedule of Medical Benefits. Any coverage that is not shown in the Schedule of Medical Benefits is not provided under the Plan.
- 2.2 “SmartHealth Network Coverage”
- A. Covered Persons must obtain medical services from Tier 1 or Tier 2 providers in order to receive Tier 1 or Tier 2 benefits under the Program, unless medical services are obtained as a result of a Medical Emergency.
 - B. Covered Persons may go to their Home Ministry to obtain eligible services, in which case they will pay the Co-Pays and/or Copayments as listed in the Tier 1 column of the Schedule of Medical Benefits (see Section 2.3.A). Benefits for these eligible services will be paid as listed on the Schedule of Medical Benefits for all Covered Expenses, subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations.
 - C. If eligible services are unavailable from the Covered Person’s Home Ministry, the Covered Person may go to:
 - 1. Any other Tier 1 provider and pay Tier 1 Co-Pays and Copayments as listed in the Tier 1 column of the Schedule of Medical Benefits (see Section 2.3.A), subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations, or
 - 2. Any Tier 2 provider designated for the specific service/circumstance as stated in the Provider Directory (available at www.SmartHealth-MI.org by searching under Provider Directory and Facility/Other Services) and pay Tier 1 Co-Pays (excluding

Office Visits) and Copayments as listed in the Tier 1 column of the Schedule of Medical Benefits (see Section 2.3.A), subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations, or

3. Any Tier 2 provider not listed in the Provider Directory (available at www.SmartHealth-MI.org by searching under Provider Directory and Facility/Other Services) and pay Tier 2 Co-Pays, Copayments and Deductibles as listed in the Tier 2 column of the Schedule of Medical Benefits (see Section 2.3.A), subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations, or
 4. Any Tier 2 provider, after Prior Authorization for services approved by the Managed Care Representative and pay Tier 1 Co-Pays (excluding Office Visits) and Copayments as listed in the Tier 1 column of the Schedule of Medical benefits (see Section 2.3A), subject to Reasonable and Customary, Annual Lifetime and Other Maximums, General Exclusions and all applicable limitations.
- D. If a Covered Person receives eligible services from either a Tier 1 or Tier 2 facility/provider as the result of a Medical Emergency, Tier 1 benefits will be paid subject to the applicable Tier's Co-Pays, Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations.
- E. If a Covered Person receives eligible services from a facility/provider other than a Tier 1 or Tier 2 provider as a result of a Medical Emergency, benefits are available through Co-Pays as listed in the Tier 2 column of the Schedule of Medical Benefits (see Section 2.3.A), subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations, including Balance Billing.
- F. If a Covered Person receives services from a facility/provider other than a Tier 1 or Tier 2 provider that are not the result of a Medical Emergency, the services are not covered.

2.3 "Schedule of Medical Benefits"

- A. See the Schedule of Medical Benefits on the following page.
- B. Services listed in Section 2.7 require Prior Authorization in order to receive Tier 1 or Tier 2 benefits. Benefits for these eligible services will be paid as listed on the Schedule of Medical Benefits for all Covered Expenses, subject to Reasonable and Customary, Annual, Lifetime and Other Maximums, General Exclusions and all applicable limitations, including Balance Billing.
- C. If admitted to a Hospital from the Emergency Room, no Emergency Room Co-Pay is applied to any charge incurred in the Emergency Room.
 1. Saginaw Only: Emergency Services for St. Mary's of Michigan Saginaw associates available at Towne Centre for a \$40 co-pay for both levels of care (Emergency Care & Urgent Care). The \$40 co-pay will not be waived if an admission occurs as a result of the emergency visit.

Schedule of Medical Benefits



SmartHealth Network

Deductibles/Co-Pays/ Copayments and Plan Maximums	Tier 1 <i>Ascension Health Michigan Network</i>	Tier 2 (See Notes below) <i>Community Blue/Blue Preferred PPO Network</i>
Deductible <ul style="list-style-type: none"> ▪ Individual ▪ Family 	\$0 \$0	\$ 750 \$1,500
Co-Pays <ul style="list-style-type: none"> ▪ Office/Primary ▪ Mental Health/Substance Abuse Individual/Group Therapy ▪ Office/Specialist ▪ Urgent Care ▪ ER ▪ Inpatient Admission 	\$15 Co-Pay \$15 Co-Pay \$20 Co-Pay \$20 Co-Pay \$100 Co-Pay \$100 Co-Pay	\$20 Co-Pay \$20 Co-Pay \$30 Co-Pay \$40 Co-Pay \$125 Co-Pay \$150 Co-Pay
Copayments <ul style="list-style-type: none"> ▪ Plan pays ▪ You pay 	100% 0% except for Chiropractic, DME/P&O	80% after Deductible 20% after Deductible
Lifetime Maximum	\$2 million	
Annual Out-Of-Pocket Maximum <ul style="list-style-type: none"> ▪ Individual ▪ Family ▪ Inpatient Admission Co-Pay per Family 	N/A N/A \$300	\$3,000 \$6,000 \$ 450
Services		
Preventive Services <ul style="list-style-type: none"> ▪ Annual Routine Physical ▪ Well Baby/Child Care ▪ Annual Gynecological Exam ▪ Routine Immunizations ▪ Colonoscopy ▪ Annual Screening Mammogram 	\$0 \$0 \$0 \$0 \$0 \$0	\$20 Co-Pay \$20 Co-Pay \$20 Co-Pay 20% after Deductible 20% after Deductible 20% after Deductible
Wellness/Disease Management <ul style="list-style-type: none"> ▪ Diabetic Education & Support ▪ Health Coach, Special Needs/Wellness Assistance (cost-sharing may apply) ▪ Dietetic Support/Healthy-eating Guides ▪ Catastrophic Case Management Asthma, Diabetes, Obesity, Multi-Skeletal, Congestive Heart Failure, Mental Health ▪ Smoking Cessation ▪ Nurse Case Manager 	\$0 Prior Authorization Required \$0 \$0 \$0 \$0 - Prior Authorization Required	Not Covered Not Covered Not Covered Not Covered Not Covered Not Covered
Note: (1) For very specific services specified in the Provider Directory (available at www.SmartHealth-mi.org), the associate pays Tier 1 Co-Pays even if services are provided by a Tier 2 provider (excluding Office Visit Co-Pays). (2) Any claim incurred in Tier 2 could result in Balance Billing and/or additional charges to the member. (3) Prior Authorization Required - Failure to secure "Prior Authorization" for services noted in the Plan Document will result in no coverage/benefit paid under the Plan. (4) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.		

Schedule of Medical Benefits



SmartHealth Network

	SmartHealth Network	
Services, continued	Tier 1	Tier 2 (See Notes below)
	<i>Ascension Health Michigan Ministry</i>	<i>Community Blue/Blue Preferred PPO Network</i>
Outpatient/Diagnostic Services <ul style="list-style-type: none"> ▪ Lab, Pathology, Radiology, Anesthesia ▪ Outpatient Surgery ▪ Radiation & Chemotherapy ▪ Diagnostic Infertility Testing ▪ Physical/Occupational/Speech Therapy (60 maximum visits per condition) ▪ Observation Stay (under 24 hrs) ▪ Dialysis 	\$0 \$0 \$0 \$0 \$0 \$0 \$0	20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible
Office Visit <ul style="list-style-type: none"> ▪ Primary Care (Family Practice/General Internal Medicine/Pediatrics) ▪ Specialist (Including OB/GYN) ▪ Pre/Postnatal Care 	\$15 Co-Pay \$20 Co-Pay \$20 Co-Pay (once per Pregnancy)	\$20 Co-Pay \$30 Co-Pay \$30 Co-Pay (once per Pregnancy)
Mental Health/Substance Abuse <ul style="list-style-type: none"> ▪ Inpatient Per Admission Co-Pay ▪ Partial Day Treatment ▪ Intensive Outpatient Therapy w/ Domicile ▪ Intensive Outpatient Therapy ▪ Individual Therapy ▪ Group Therapy 	\$100 Co-Pay \$0 \$0 \$0 \$15 Co-Pay \$15 Co-Pay	\$150 Co-Pay, plus 20% after Deductible 20% after Deductible 20% after Deductible 20% after Deductible \$20 Co-Pay \$20 Co-Pay
Emergency Care <ul style="list-style-type: none"> ▪ ER <ul style="list-style-type: none"> If Observation Occurs If Admission Occurs ▪ Urgent Care ▪ Ambulance ▪ Medical Transfer/Transport (air/other) 	\$100 Co-Pay \$0 \$0 \$20 Co-Pay \$0 Prior Authorization Required	\$125 Co-Pay \$0 \$0 \$40 Co-Pay \$0 Prior Authorization Required

Note: (1) For very specific services specified in the Provider Directory (available at www.SmartHealth-mi.org), the associate pays Tier 1 Co-Pays even if services are provided by a Tier 2 provider (excluding Office Visit Co-Pays).
 (2) Any claim incurred in Tier 2 could result in Balance Billing and/or additional charges to the member.
 (3) Prior Authorization Required - Failure to secure "Prior Authorization" for services noted in the Plan Document will result in no coverage/benefit paid under the Plan.
 (4) Deductibles, Co-Pays, and Balance Billing do not accrue toward Annual Out-Of-Pocket Maximum.

2.4 " Medical Benefit Maximums"

A. Calendar Year. Benefits due to any Covered Person shall not be payable in excess of the Calendar Year coverage maximum for each Covered Person as follows:

1. Annual Screening Mammogram 1 test
2. Extended Care Facility..... 120 days
3. Annual Routine Physical..... 1 exam
4. Annual Gynecological Exam..... 1 exam
5. Chiropractic Services.....\$1,000
6. Outpatient (including Home Care) Physical Therapy...60 visits per condition
7. Outpatient (including Home Care) Occupational Therapy.....60 visits per condition
8. Outpatient (including Home Care) Speech Therapy...60 visits per condition
9. Diabetes Education One Program
10. Prescription Support Stockings.....4 pairs annually

B. Other. Benefits due to any Covered Person shall not be payable in excess of the Coverage Maximum for each Covered Person as follows:

1. Hearing Aid \$2,000 every 3 calendar years
2. Hearing Aid Dispensing fee
(includes Hearing Aid check)..... \$250 every 3 calendar years

C. Lifetime. Benefits due to any Covered Person shall not be payable in excess of the Lifetime Coverage Maximum for each Covered Person as follows:

1. Hospice care (non-Tier 1).....\$7,500
2. Power operated vehicle One
3. Comprehensive Medical Weight Loss Program..... One
4. Bariatric Surgery One
5. All medical benefits combined\$2,000,000

2.5 "Description of Covered Medical Benefits" The Plan will pay a percentage of Covered Expenses incurred by a Covered Person to the extent that those charges exceed any Deductible and/or Co-Pay amount pursuant to the Schedule of Medical Benefits. To the extent a non-participating provider charges the full fee in excess of Covered Expenses, the Covered Person may be billed for the balance.

A. Deductible — A Deductible amount shall be applied to certain Covered Expenses incurred by an individual or family eligible for benefits in any calendar year. Deductibles are:

Deductibles	Tier 1	Tier 2
Individual	\$0	\$750
Family	\$0	\$1,500

- B. Annual Out-of-Pocket Maximum — After the Deductible has been paid, the total of Covered Expenses withheld because of the Copayment provisions for charges incurred in any calendar year by the Covered Person shall not exceed:

Out-of-Pocket Maximum	Tier 1	Tier 2
Individual	N/A	\$3,000
Family	N/A	\$6,000

After the Annual Out-of-Pocket Maximum has been reached, the Plan will pay up to the maximums outlined in the Plan. Co-Pays and Balance Billing amounts (which are the responsibility of the Covered Person) do not count toward the Annual Out-of-Pocket Maximum.

- 2.6 **“Covered Medical Expenses”** The Plan will pay the Tier 1 approved amount or the Tier 2 approved amount for Covered Expenses incurred subject to all Plan provisions at the percentage listed for all Covered Expenses, subject to Annual and Lifetime Maximums, General Exclusions, specific Exclusions under Covered Medical Expenses and other applicable limitations. The Plan will pay the Reasonable and Customary Charges for Covered Expenses, at the percentage listed for all Covered Expenses, subject to Annual and Lifetime Maximums, General Exclusions and other applicable limitations, including Balance Billing.

A. Covered Medical Expenses include:

1. Room and Board and Special Care Unit accommodations furnished by a qualified Hospital while the Covered Person is Hospital Confined. Birthing Center accommodations are included.

Exclusions — Expenses will *not* be paid for:

1. *Hospital Confinement charges incurred in a facility other than an approved Hospital; or*
 2. *Hospital Confinements primarily for physical check-ups, and rest cures; or*
 3. *Charges for convenience items, including TV, telephone, guest beds, etc.*
2. Hospital services and supplies furnished by a qualified Hospital to a Covered Person while Hospital Confined or Outpatient, such as operating room, x-rays, laboratory tests, drugs, medicines, general nursing care, anesthesia, radiation therapy, and blood or blood plasma.
 3. Hospital Observation Stay services.
 4. For mothers and newborns, a Hospital admission of 48 hours following a vaginal delivery, or 96 hours following a Cesarean delivery, for an eligible admission.
 5. Care for routine nursery charges for a newborn child. The requirement that the Hospital Confinement be as a result of Injury or Illness will not apply with respect to the charges incurred in connection with the Hospital Confinement of a newborn child while such child's mother is confined in the

Covered Medical Expenses continued...

Hospital. Also eligible shall be the routine Physician visits during the initial Hospital Confinement.

Exclusion — Expenses will *not* be paid for: *the initial examination of a newborn by the delivery Physician.*

6. Surgical Procedures including preoperative and postoperative care.
7. Ambulatory Care Center charges in connection with a covered Surgical Procedure.
8. Services of a technical surgical assistant when deemed to be required for a Surgical Procedure or obstetrical procedure.
9. Anesthetics and oxygen and their administration by a Physician or Certified Registered Nurse Anesthetist (CRNA).

Exclusion — Expenses will *not* be paid for:

1. *anesthesia for procedures which are not covered by the Plan; and*
2. *supervision of more than four CRNAs.*

10. Treatment of Injuries to Sound Natural Teeth under the following circumstances:
 - a. the treatment must be necessary due to accidental damage to the tooth; and
 - b. the damage was severe enough to be evaluated by a Physician or Dentist within 72 hours of the accident; and
 - c. the dental services are provided by a DDS or an oral and maxillo-facial surgeon; and
 - d. the dental services are started within 3 months of the accidental Injury and are completed within 12 months of the accident.
11. Potential dental procedures as follows:
 - a. excision or removal of lesions and tumors, including non-odontogenic cysts, tumors, or lesions of the jaws, cheeks, lips, tongue, roof and floor of mouth; or
 - b. excision of benign bony growths of the jaw and hard palate; or
 - c. incision of sensory sinuses, salivary glands, or ducts; or
 - d. surgery to correct Injuries to the jaws, cheeks, lips, tongue, floor and roof of mouth.

Exclusions — Expenses will *not* be paid for:

1. *vestibuloplasty; or*
2. *in connection with the prevention or correction of malocclusion of the teeth by wire braces or any other treatment methods; or*
3. *treatment of periodontal or periapical disease; or*
4. *any condition involving teeth or surrounding tissue or structure; or*

Covered Medical Expenses continued...

5. *any dental services, dental prostheses, dental implants, and dental x-rays unless the service is eligible under Covered Medical Expenses; or*
 6. *excision/destruction of dentoalveolar structures; with or without repair.*
12. Hospital Charges for:
 - a. multiple tooth extractions and/or removal of un-erupted teeth when required due to a related medical condition; or
 - b. when a concurrent medical condition exists which prevents the dental procedure(s) from being safely performed in an office setting; or
 - c. treatment of Injuries to Sound Natural Teeth.
 13. Diagnostic radiology and procedures, laboratory testing and pathological examinations when ordered by a Physician for the diagnosis of an Illness or Injury.
 14. Infertility testing.
 15. Genetic testing to determine the viability of a Pregnancy or to diagnose a potential birth defect prior to Pregnancy.
Exclusion — Expenses will *not* be paid for: *paternity testing*.
 16. BRCA1 and BRCA2 genetic testing and pre-test education.
 17. Oncotype DX Gene Expression Profiling for breast cancer.
 18. Prescribed Medical supplies and treatment, home and office visits by a Physician and other medical care as deemed necessary for the treatment of an Illness or Injury. The Plan also provides benefits for visits by a Physician during the period of Hospital Confinement.
 19. Pre and postnatal care, including required visits to the doctor's office and Reasonably Necessary laboratory tests related to a covered Pregnancy.
 20. Circumcisions.
 21. Cosmetic Surgery when performed to correct deformities under the following circumstances:
 - a. as a result of an Injury or Illness; or
 - b. as a result of a congenital defect which interferes with a function of the body; or
 - c. scar revision necessary to correct a deformity caused by an accidental Injury or Surgical Procedure.

Covered Medical Expenses continued...

Exclusions — Expenses will *not* be paid for:

1. *excision of excessive skin and subcutaneous tissue (including lipectomy) of the thigh, leg, hip, buttock, arm, forearm or hand, submental fat pad, or other area (excludes abdomen); or*
 2. *suction assisted lipectomy of the head and neck, trunk (unless performed in conjunction with abdominoplasty or panniculectomy), upper extremity or lower extremity; or*
 3. *breast implants for solely cosmetic reasons, except when specifically provided under Covered Services; or*
 4. *dermabrasion; or*
 5. *cryotherapy for acne; or*
 6. *chemical exfoliation for acne.*
22. Charges for or in connection with a mastectomy consistent with The Women's Health & Cancer Rights Act of 1998 (see Section 14.12), including the following:
- a. Reconstruction of the breast on which the mastectomy was performed;
 - b. Surgical Procedures and reconstruction of the other breast, to produce a symmetrical appearance;
 - c. Protheses and physical complications of all stages of mastectomy, including lymphedemas; and
 - d. Mastectomy brassieres up to 2 every 6 months.
23. Blood and blood plasma, and their administration.
24. Autologous blood transfer and blood storage.
25. Hemodialysis.
26. Chemotherapy.
27. X-ray and radium treatments and treatments with other radioactive substances.
28. Eyeglasses including frames or contact lens following cataract surgery up to \$250 maximum.
29. Professional ground or air ambulance required because of an accidental bodily Injury or a Medical Emergency to the nearest point of medical treatment (including the transfer of an unstable Covered Person if the Covered Person requires equipment, services or personnel not available at the facility). Reasonably Necessary, non-emergency transfer via an appropriately equipped vehicle from one facility to another or from a facility to home.
30. Diagnostic hearing exams.

Covered Medical Expenses continued...

31. Hearing aid(s) up to \$2,000 per Covered Person every three (3) years when received from a designated Tier 1 provider.

Exclusion — Expenses will *not* be paid for: *batteries*

32. Cochlear implants.

33. Prescribed Medical Supplies

a. Artificial eyes and larynx;

b. Electronic heart pacemaker;

c. Casts, splints, trusses;

d. Wound care/dressing supplies;

e. Prescription support stockings, up to 4 pairs annually;

f. DME rental (or at the Plan's option, purchase, if the Plan Administrator determines that the cost of purchase is less than anticipated total rental charges or the most appropriate avenue of obtaining equipment). Examples of DME: standard wheelchair, Hospital bed, oxygen and equipment, etc.

- Exceptions are phototherapy blankets, apnea monitors (rental item only) and pulse oximeters.
- Rent-to-purchase conversion equals 12 months for a Tier 1 provider and 10 months for a Tier 2 provider.
- The Covered Person will hold the title to the equipment.
- Reimbursement for support services, e.g., set-up, delivery, training, on-going assistance, etc., are included in the reimbursement for the DME item.
- St. Joseph Health System Members Only: Diabetic supplies (glucose meters, test strips, lancets and lancet devices, and diabetic control solutions) when obtained through St. Joseph Health System DME.

Exclusions — Expenses will *not* be paid for:

1. *air conditioners, purifiers, humidifiers, heating pads, cold pads, hot water bottles; or*
2. *elastic bandages, blood pressure kits, first aid kits; or*
3. *Percutaneous Electrical Nerve Stimulation for peripheral nerve stimulation; or*
4. *electronically controlled thermal (hot or cold)/compression therapy units with mechanical pumps; or*
5. *pulsed electrical stimulation units for osteoarthritis; e.g., The BioniCare® System BIO-1000™; or*

Covered Medical Expenses continued...

- 6. *low density ultrasound stimulation to aid bone healing, noninvasive; or*
- 7. *convenience items.*

- g. Prosthetics, orthotics, braces (including attached corrective shoes);

Exclusions — Expenses will *not* be paid for:

- 1. *myoelectronic limbs; or*
- 2. *orthopedic shoes (except those which are an integral part of a corrective brace); or*
- 3. *corrective shoes; or*
- 4. *arch supports; or*
- 5. *foot orthotics.*

- h. Other prescribed medical supplies.

- 34. Physiotherapy treatment by a licensed physiotherapist and occupational therapy by a licensed occupational therapist.

- 35. Treatment by a licensed, qualified speech therapist for the purpose of restoring speech loss or correcting an impairment due to:

- a. a congenital defect for which corrective surgery has been performed; or
- b. an Injury or Illness which caused the loss of the ability to speak, except a mental, psychoneurotic or personality disorder.

Exclusion — Expenses will *not* be paid for: *treatment by a licensed qualified speech therapist for the purpose of correcting an impairment due to development delay.*

- 36. Hospice Care Program expenses if a Physician's statement is received which verifies that the Covered Person's life expectancy is no longer than six (6) months. The exclusion for Custodial Care does not apply to the Hospice Care Program benefits.

- 37. Home Health Agency care expenses for services furnished in the Covered Person's home as follows, if a Physician orders the services of a Home Health Agency:

- a. Part-time or intermittent nursing care by or under the supervision of a registered nurse. Each visit by a member of a Home Health Agency care team, consisting of not more than 4 hours of service, will be considered one Home Health Agency care visit.
- b. Physical therapy, occupational therapy, speech therapy;

Covered Medical Expenses continued...

- c. Medical supplies;
 - d. Masters prepared social workers (MSW).
38. Home uterine monitoring, including devices.
39. Extended Care Facility expenses including:
- a. Semi-Private Room and Board;
 - b. Other services and supplies ordered by a Physician and furnished by the Extended Care Facility for Inpatient medical care;
 - c. Private duty nursing or other professional services only if the patient is under the continuous care of their Physician or 24-hour nursing care is essential.

Exclusions — Expenses will *not* be paid for:

- 1. *Custodial Care; or*
 - 2. *confinements for Psychiatric Treatment and/or Substance Abuse care.*
40. Psychiatric Treatment and Substance Abuse care for:
- a. Hospital and Accredited Care Facility admissions;
 - b. Partial Hospital Confinement provided by Hospitals or Accredited care facilities. All eligible charges in conjunction with this care shall be considered as charges of a Hospital Confinement.
 - c. Electroshock therapy when administered by a Physician;
 - d. Anesthesia for electroshock therapy when administered by a Physician other than the Physician administering the electroshock therapy or by a CRNA;
 - e. Detoxification, including Voluntary Sub-acute Detoxification, provided by a Hospital or Accredited Care facility;
 - f. Intensive Outpatient Therapy provided by a Hospital or Accredited Care Facility;
 - g. Intensive Outpatient Therapy with domicile provided by an approved facility;
 - h. Individual, Family or Group counseling or therapy provided by a licensed psychiatrist (MD or DO license), licensed psychologist (LP license – Doctorate Psychologist), limited licensed psychologist (LLP license – Masters Psychologist), licensed professional counselor (LPC license – Masters Counselor), licensed master social worker (LMSW license – Masters Social Worker), and licensed nurse

Covered Medical Expenses continued...

with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license);

- i. Psychiatric evaluation, treatment, and medication reviews when provided by a psychiatrist;
- j. Psychological, Neuropsychological or Neurobehavioral Status testing provided by a psychiatrist or person qualified in the particular area of testing.

Exclusions — Expenses will *not* be paid for:

- 1. *professional services for Psychiatric Treatment and Substance Abuse care provided by anyone other than a licensed psychiatrist (MD or DO license), licensed psychologist (LP license – Doctorate Psychologist), limited licensed psychologist (LLP license – Masters Psychologist), licensed professional counselor (LPC license – Masters Counselor), licensed master social worker (LMSW license – Masters Social Worker), and licensed nurse with a specialty in psychiatry (Masters of Science in Nursing with RN license) or Nurse Practitioner (NP with RN license); and*
- 2. *any treatment not listed in Section 2.6.A.40 above.*

- 41. Human Organ benefits are provided only for Reasonably Necessary services.

Also covered are charges for obtaining donor organs when the recipient is a Covered Person. Donor charges include those for evaluating the organ, removing the organ from the donor, and transportation of the organ from within the United States and Canada to the place where the transplant is to take place. When the donor has medical coverage, her plan will pay primary. The benefits under this Plan will be reduced by those payable under the donor's plan.

If the organ donor is a Covered Person and the recipient is not, then the Plan will cover donor organ charges for evaluating the organ and removing the organ from the donor.

Stem cell transplants (bone marrow, peripheral blood, and umbilical cord blood stem cells) shall be covered for any condition deemed to be Reasonably Necessary. The Exclusions that exclude procedures, treatment, services, supplies or drugs not approved by the Federal Food and Drug Administration of the United States, or which are considered as Experimental Treatment or investigative, shall not apply to stem cell transplants.

Stem cell transplants, from the Covered Person, from an HLA-compatible donor, or from HLA-compatible umbilical cord blood, with or without high dose chemotherapy are covered benefits. An HLA-compatible donor is defined as

Covered Medical Expenses continued...

an immediate relative or a donor outside of the immediate family with either the same or five of the six important genetic markers* as the patient. An HLA-compatible umbilical cord blood donor is defined as having four of the six important genetic markers* as the patient.

* Genetic markers are specific chemical groupings of white blood cells (human leukocyte antigens [HLA]) used to detect the constitutional similarity of one person to another. The important markers are HLA-A, HLA-B and HLA-DR from both parents.

Also covered are donor charges when the recipient is a Covered Person. Donor charges include those for activation of an unrelated donor search through the National Marrow Donor Program (NMDP), confirmatory typing of donor samples (including infectious disease tests), genetic evaluation, stem cell collection, and transportation of the stem cell to the place where the transplant is to take place. If the stem cell donor is a Covered Person and the recipient is not, then the Plan will cover donor charges for genetic evaluation and collection of the stem cells. When the donor has medical coverage, her plan will pay primary. The benefits under this Plan will be reduced by those payable under the donor's plan.

Exclusion — Expenses will *not* be paid for:

1. *organ/stem cell transportation charges in relation to human organ or stem cell transplant when the donor is a Covered Person and the recipient is not; and*
2. *kidney, cornea, and pancreas transplants when not performed by a Tier 1 Physician in a Tier 1 facility.*

42. Wellness Care Benefits for the following:

- a. Annual routine physical and/or gynecological examinations including related testing.
- b. Well baby/child examinations including related testing.
- c. Annual screening mammogram.
- d. Pap smears.
- e. Routine Immunizations.

Exclusion — Expenses will *not* be paid for:

1. *Vaccines for travel.*
 2. *Saginaw Only: Routine immunizations obtained in any venue other than St. Mary's of Michigan Saginaw Associate Health Department. (Coverage available only through the Associate Health Department.)*
- f. Prostate specific antigen (PSA) test.

Covered Medical Expenses continued...

g. Colonoscopy.

h. Flexible sigmoidoscopy.

43. Cardiac Rehabilitation -- Phases I and II. Phase I provided in Inpatient setting.

Phase II for patients who (1) have a documented diagnosis of acute myocardial infarction within the preceding 12 months; or (2) have had coronary bypass surgery; or (3) have had balloon angioplasty; or (4) have had a cardiac transplant; or (5) have had a heart valve replacement; or (6) have congestive heart failure; and/or (7) have stable angina pectoris.

Exclusion — Expenses will *not* be paid for: *Cardiac Rehabilitation – Phase III.*

44. Diabetes education and dietetic support when received from a Tier 1 provider.

45. Health Coach, Wellness Assistance, Nurse Case Manager, and Catastrophic Case Management when received by a Tier 1 provider.

46. Smoking Cessation when received by a Tier 1 provider.

47. Pulmonary Rehabilitation.

48. Cognitive Rehabilitation when required as a result of Illness or Injury.

49. Charges for surcharge fees mandated under the New York Health Care Reform Act (HCRA). Notwithstanding this provision, surcharge fees mandated under the New York Health Care Reform Act shall not be considered Covered Expenses and shall be excluded if the surcharges do not apply or the act is invalidated by a court of competent jurisdiction.

50. Medical/Surgical treatment for complications resulting from non-covered procedures.

51. Enteral tube feedings with prescription nutritional formulas for nutritional support.

Exclusions — Expenses will *not* be paid for:

1. *Nutritional support taken orally; or*
2. *Non-prescription food supplements; or*
3. *Standard infant formulas.*

52. Physician supervised weight loss services or a comprehensive *SmartHealth* medical weight loss program when received from a Tier 1 provider.

Exclusions — Expenses will *not* be paid for:

1. *Nutrition/dietician services offered in a Physician's office; or*
2. *Exercise services offered in a Physician's office; or*
3. *Diet supplements and/or meal replacements; or*

Covered Medical Expenses continued...

4. *Weight loss drugs; or*
5. *Other weight loss programs, e.g., Weight Watchers, Jenny Craig, etc.*

53. Bariatric surgery when performed by a Tier 1 Physician in a Tier 1 facility.

Exclusions — Expenses will *not* be paid for:

1. *Vertical-banded gastroplasty; or*
2. *Other gastric restrictive procedures, without gastric bypass, for morbid obesity; or*
3. *A biliopancreatic diversion with duodenal switch for morbid obesity; or*
4. *Revision or reversal of a gastric restrictive procedure is limited to failure of the procedure due to complications of anatomic or technical reasons*

54. Biofeedback for the treatment of urinary incontinence.

Exclusion — Expenses will *not* be paid for: *biofeedback for any indication other than urinary incontinence.*

55. Charges for temporomandibular joint (TMJ) appliances.

56. Cyber Knife when performed by a Tier 1 Physician in a Tier 1 facility.

57. Magnetic resonance guided focused ultrasound for the treatment of leiomyomata when performed by a Tier 1 Physician in a Tier 1 facility.

2.7 **"Prior Authorization Requirements"** Prior Authorization means that the Covered Person must receive prior approval before obtaining certain medical services. A medical review is performed to determine if the services are Reasonably Necessary. The doctor or ordering Physician must submit the necessary paperwork. If you have Medicare primary, the requirement does not apply.

All services listed below shall require Prior Authorization by the Managed Care Representative chosen by the Plan Administrator to determine if requested services are Reasonably Necessary. No benefit shall be paid on behalf of the Covered Person if the required authorization is not obtained by the requesting provider at least 48 hours prior to the date the service is to be rendered. Furthermore, no benefit shall be paid if the Covered Person fails to abide by the decisions of the Managed Care Representative chosen by the Plan Administrator.

A. The following is a list of services that require Prior Authorization:

1. Abdomen
 - Abdominoplasty/Panniculectomy
 - Lipectomy – suction assisted when performed in conjunction with abdominoplasty/panniculectomy

2. Breast
 - Breast repair and/or reconstruction, including nipple/aerola reconstruction and correction of inverted nipples
 - Breast reduction
 - Mastectomy for gynecomastia

3. Eye
 - Blepharoplasty – lower and upper eyelid
 - Canthopexy
 - Canthoplasty
 - Canthotomy
 - Ectropian – repair
 - Entropian – repair
 - Correction of lid retraction

4. Face
 - Bone grafts – nasal; mandibular; maxillary; or malar areas/rib cartilage to face, chin, nose or ear; ear cartilage to nose or ear
 - Brow ptosis; blepharoptosis – repair or reduction of overcorrection of ptosis
 - Coronoideotomy
 - Cranial bones reconstruction
 - Forehead reduction/reconstruction
 - Genioplasty
 - Lip – excision/reconstruction
 - Malar augmentation
 - Mandibular angle augmentation
 - Mandibular reconstruction
 - Masseter muscle and bone reduction
 - Midface reconstruction
 - Orbital reconstruction/repositioning
 - Orbitocraniofacial reconstruction – secondary revision
 - Osteoplasty – facial bones, augmentation/reduction
 - Osteotomy – mandible; maxilla
 - Otoplasty – protruding ear
 - Zygomatic arch and glenoid fossa reconstruction
 - Temporomandibular Joint – arthroplasty/closed & open treatment of dislocation

5. Nose
 - Endoscopy – nasal/sinus w/concha bullosa resection
 - Inferior turbinate – excision/resection
 - Nasal vestibular stenosis – repair
 - Rhinophyma – excision/surgical planing of skin
 - Rhinoplasty
 - Septal or other intranasal dermatoplasty
 - Septoplasty or submucous resection

6. Skin
 - Abrasion (e.g., keratosis, scar) – single and multiple
 - Adjacent tissue transfer or rearrangement – eyelids, nose, ears, and/or lips except when performed for the following diagnoses: 140.0 – 140.9, 147.3, 149.8, 160.0, 160.1, 160.8, 170.0, 171.0, 173.0 – 173.3, 195.0, 230.0, 231.8, 232.0 – 232.3, 234.8
 - Dermal and epidermal substitutes
 - Destruction of benign lesions other than skin tags or cutaneous vascular proliferative lesions, excluding when performed for the following diagnoses: 078.0, 078.1, 078.1x, 216.0 – 216.9, 702.0, 702.11, V10.82, V10.83
 - Destruction of cutaneous vascular proliferative lesions
7. Throat/Neck
 - Cervicoplasty
 - Palatopharyngoplasty
8. Varicose Veins
 - Echosclerotherapy
 - Endovenous ablation therapy for varicose veins – radiofrequency and laser
 - Implantable endovascular ablation catheter
 - Ligation/division/stripping
 - Sclerotherapy
 - Stab phlebectomy
 - Subfascial endoscopic perforator surgery (SEPS)
9. Ambulance
 - Special care transport
 - Air
 - Wheelchair van/other
 - Nonemergency transport when transferred to a residential, domiciliary or custodial facility, an End-Stage Renal Disease facility, a physician's office, or a residence
10. Diagnostic Tests
 - BRCA1 and BRCA2 genetic testing
 - Capsule Endoscopy
 - Neuropsychological testing
 - Oncotype DX – gene expression profiling panel for the management of breast cancer treatment
 - Positron Emission Tomography (PET Scan)
11. Hearing
 - Cochlear hearing device implantation
 - Electromagnetic bone conduction hearing device – implantation/ replacement/removal/repair
 - Osseointegrated implant – temporal bone, w/percutaneous attachment to external speech processor/cochlear stimulator

12. Hospital Confinements
 - Skilled Nursing Facility confinements when *SmartHealth* is the primary insurer, excluding Hospice admissions
 - Occurring outside the Ascension Health Michigan Network (Tier 1) as a result of a Medical Emergency

13. Services when performed in a Hospital/facility setting
 - Bone marrow biopsy
 - Cryocautery of the cervix
 - Dental services
 - Proctosigmoidoscopy
 - Sigmoidoscopy

14. Transplants
 - Organ
 - Cornea
 - Bone Marrow

15. Treatments/Therapies
 - Bariatric Surgery
 - Cognitive Rehabilitation
 - Electrical stimulation to aid bone healing – invasive and non-invasive
 - Fetal surgery
 - Hyperbaric oxygen therapy
 - Intrauterine device – insertion/removal for a medical condition
 - Laser treatment for inflammatory skin disease (psoriasis)
 - Magnetic resonance guided focused ultrasound for the treatment of uterine leiomyomata
 - Photochemotherapy/UVL treatment for the following diagnoses: 691.8 – atopic dermatitis, 202.1x – mycosis fungoides, 202.21 – Sezary's disease
 - Speech/Voice therapy, excluding when performed for the following diagnoses: 434.01, 434.11, 434.91, 435.9, 436, 674.0, 997.02
 - Spinal cord stimulation

16. Miscellaneous Services
 - Borgess Health Members – services from the following providers:
 - Bronson Medical Group
 - Bronson Methodist Hospital
 - Lakeland Healthcare
 - Metro Health
 - Spectrum Health
 - Coverage of Tier 2 providers/services at Tier 1 Co-Pays/ Copayments, excluding Office Visits
 - Interdental fixation device or wiring for conditions other than fracture or dislocation
 - Penile prosthesis – insertion/repair/replacement
 - Penile revascularization
 - Penile venous occlusive procedure
 - Synagis™ injections (respiratory syncytial virus immune globulin)

- Unlisted services/procedures – ambulance; breast; craniofacial; dermatological special service or procedure; eyelids; maxillofacial; mucous membrane; nose; skin; stomach; subcutaneous tissue

B. Additional Authorization Requirements

Hospital confinements occurring outside the Ascension Health Michigan Network (Tier 1) as a result of a Medical Emergency. No benefit shall be paid on behalf of the Covered Person if the required authorization is not obtained by the requesting provider/facility. Furthermore, no benefit shall be paid if the Covered Person fails to abide by the decisions of the Managed Care Representative chosen by the Plan Administrator.

Continued length-of-stay review is required for all authorized Skilled Nursing Facility confinements when *SmartHealth* is the primary insurer. No benefit shall be paid if the Covered Person fails to abide by the decisions of the Managed Care Representative chosen by the Plan Administrator.

ARTICLE 3—MEDICAL EXCLUSIONS

3.1 "General Exclusions" The calculation of benefits payable under this Plan shall not include or be based upon any charge made for the following services or supplies:

1. furnished before the date on which the individual on whose account the charge was made became a Covered Person or which was furnished in connection with or during a Hospital confinement which commenced before that date; or
2. for charges for services incurred after eligibility is terminated; or
3. for charges for any benefits that are available to the Covered Person through a prior benefit plan's extension of benefits; or
4. which would not have been made in the absence of coverage, or which the Covered Person is not legally obligated to pay or to the extent that the Plan Administrator is prohibited from providing benefits for such charge, by any law or regulation; or
5. which claim for benefits is made more than 24 months after the expense is incurred unless this Plan is the secondary carrier in which case the claim for benefits can be extended to within 6 months from the date of the primary carrier's payment; or
6. for services rendered for treatment of an Injury or Illness for which benefits are available under Workers' Compensation or employer liability law, or services rendered for any occupational Injury or Illness sustained as a result of any work for wage or profit, except that an individual proprietor or partner who is covered under this Plan, and who is not eligible to be covered by the Workers' Compensation Law or similar law in the jurisdiction of their principle place of employment, shall have benefits available to her in connection with occupational Injuries and Illnesses, subject to all other applicable terms and conditions of this Plan; or

7. furnished by or through any government or any subdivision or agency, or the charge for which is paid or payable or reimbursable by or through any plan or program of any government or any subdivision or agency, other than a plan or program established for the civilian employees of a government or of a subdivision or agency unless payment is legally required; or
8. for benefits furnished, paid for, or required by reason of service in the armed services of any country; or
9. received as a result of an act of war, whether declared or undeclared, occurring while the individual is covered; or
10. for an Injury incurred while engaged in any activity which violates any federal or state law, including the perpetration of a felony or misdemeanor; or
11. furnished without the recommendation and approval of a Physician acting within the scope of her license; or
12. not Reasonably Necessary to the care and treatment of any Injury or Illness of the Covered Person on whose account the charge is made, unless such procedure is specifically covered herein; or
13. for charges for care, treatment, services, and supplies which are not uniformly and professionally endorsed by the general medical community as standard medical care: or
14. for professional services, care, treatment and referrals rendered by the Covered Person's family including, but not limited to the mother, father, grandmother, grandfather, aunt, uncle, cousin, brother, sister, niece, nephew, son, daughter, grandson, granddaughter, or any person who resides with the Covered Person; or
15. for charges by a Christian Science facility, practitioner, or nurse; or
16. for charges for medical treatment or visits which consist only of a telephone conversation, e-mail or internet exchange, or other non-face-to-face encounter where the Covered Person and the provider of the service are not physically present in the same room at the same time; or
17. for procedures, treatment, services, supplies or drugs not approved by the Federal Food and Drug Administration of the United States; or approved by the FDA, but not for a specific condition; or
18. for procedures, treatment, services, supplies or drugs which are considered as Experimental Treatment or investigative; or
19. for services or treatment required by a third party; or
20. for private duty nursing or private duty attendants; or
21. for travel, whether or not recommended by a Physician; or

22. for treatment or services that were received outside of the United States, its protectorates, Canada or Mexico, except if the treatment is for a Medical Emergency; or
23. for ultraviolet therapy or other light therapy, except in the treatment of psoriasis, atopic dermatitis, mycosis fungoides or for Dependents under the age of one with hyperbilirubinemia; or
24. for recreational therapy; or
25. for educational testing, therapy, or training; or
26. for exercise programs; or
27. for hypnotherapy; or
28. for music therapy or reading therapy; or
29. for acupuncture or accupressure; or
30. for charges incurred for, or in connection with, sexual conversion surgery and other services related to gender reassignment or disturbance of gender identification or related sexual impotency; or
31. for care for corns, calluses, bunions, or toenails except for related Surgical Procedures; or
32. for examinations, testing, and procedures related to vision correction, including eye glasses and contact lenses, unless the service is eligible under Covered Medical Expenses; or
33. Orthoptic Training; or
34. for laser or radial keratotomies; or
35. for hair replacement including wigs, or hair removal; or
36. for pre-marital, pre-employment, or any examinations required by school, camp, licensing, or any other regulatory purposes, including all related diagnostic testing; or
37. for sterilization except in the rare medical or surgical conditions where Pregnancy represents a mortal risk to a woman because of a present and serious pathology in accordance with the Ethical and Religious Directives for Catholic Health Care Services; or
38. for sterilization reversal; or
39. for charges for or in connection with in-vitro fertilization, embryo transfer, artificial insemination; or
40. for charges in connection with multi-fetal Pregnancy reductions; or

41. for abortions, except for early induction of labor before fetal viability in cases where the mother's life is in imminent danger; or
42. for contraceptives except for treatment of a medical condition in accordance with Ethical and Religious Directives for Catholic Health Care Services; or
43. for penile implants or Durable Medical Equipment, e.g., male erection systems, unless Reasonably Necessary to correct impotence caused by organic disease or Injury; or
44. for emergency room facility and emergency room Physician charges for services in connection with a non Medical Emergency (for a definition of services that constitute an emergency, see Section 1.19, "Emergency Medical"); or
45. for charges for a provider to appear in court; or
46. for the copying of medical records; or
47. for the following diabetic supplies: glucose meters, test strips, lancets and lancet devices, and diabetic control solutions (except not excluded for St. Joseph Health System Members when obtained through St. Joseph Health System DME); or
48. for orthotripsy (Extracorporeal Shock Wave therapy); or
49. for expenses that would violate the Ethical and Religious Directives for Catholic Health Care Services, as promulgated from time to time by the United States Conference of Catholic Bishops, Washington, D.C., of the Roman Catholic Church and as adopted by the Archbishop of Detroit. If the United States Conference of Catholic Bishops ceases to exist, Ethical and Religious Directives will mean similar directives promulgated by the successor organization or by such organization that exercises the same powers and duties or by the Roman Catholic Church. If the Archbishop of Detroit shall cease to exist so that there is not an individual bearing this title, Ethical and Religious Directives will mean those adopted by the individual or organization that exercises the power, duties and authority of the Archbishop of Detroit. The Plan Administrator shall be responsible for making all determinations as to whether an expense would violate the Ethical and Religious Directives; or
50. for applied behavioral analysis, sensory integration therapy, etc., for developmental delay or any other diagnosis; or
51. for lactation consultants; or
52. for over-the-counter products; or
53. for circulating tumor cell tests for metastatic cancer; or
54. for charges for services by dependents with dual medical coverage, who do not follow their primary plan's criteria, guidelines, and networks.

ARTICLE 4—STANDARD PROVISIONS

- 4.1 "Proof of Loss" Written proof of claim must be given to the Plan Manager within 24 months from the date the expense was incurred and submitted on the appropriate claim forms as determined by the Plan Administrator. However, when a Covered Person's coverage terminates for any reason, written proof of claim must be given to the Plan Manager within 90 days of the date of termination of coverage, provided that the Plan remains in force. Claims will be paid on a timely basis by the Plan Administrator upon receipt of complete written proof. Upon termination of the Plan, final claims must be received within 30 days of termination. Written proof of claims submitted for secondary payment must be given to the Plan Manager within six months from the date the primary payor processed the claim.

Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if it shall be shown not to have been reasonably possible to furnish such proof within the required time and that proof was given as soon as was reasonably possible.

In the event that a claim is denied and the Employee appeals said denial, the Plan Administrator shall not be obligated to pay any part of said claim until a final determination has been made pursuant to the claims appeal procedure. Each fiduciary shall be responsible for the interpretation of the benefits, provisions, requirements, and exclusions contained herein as delegated to each such fiduciary.

The Plan shall have the right (at its own expense) to require a claimant to undergo a physical examination when and as often as may be reasonable.

- 4.2 "Payment of Any Claim" will be made to the person rendering the services, unless the Employee or Dependent furnishes paid receipts with her proof of claim. If the Employee dies before all benefits have been paid, the remaining benefits may be paid to any relative of the Employee or to any person or corporation appearing to the Plan to be entitled to payments. The Plan shall discharge its liability by such payments.
- 4.3 "Time of Payment of Claims" Claims made for indemnities provided under the Plan shall be deemed payable immediately upon receipt of due written proof of loss.
- 4.4 "Physical Examination and Autopsy" The employer, at its own expense, shall have the right and opportunity to have the person or any individual whose Injury or Illness is the basis of a claim, examined by a Physician designated by it, when and as often as it may reasonably require during the pendency of a claim under the Plan and to make an autopsy in case of death, where it is not forbidden by law.
- 4.5 "Assignment" Benefits payable or to be payable under this Plan shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person other than the duly authorized representatives, and by representatives only to the extent and for the purpose as herein specifically provided, except that any Employee may assign any benefits to which they or their Dependents may become entitled, to an institution in which they or their Dependents are Hospitalized, or to a Physician, medical technician, Dentist, or any other service provider as the case may be, in consideration for Hospital, medical or dental under this Plan may not in any way be anticipated, alienated, or assigned by an Employee.

- 4.6 “Nondiscrimination Requirements” The Plan shall not discriminate against any Employee, Covered Person or Dependent as to eligibility or continued eligibility for benefits nor shall the Plan discriminate in the individual premium or contribution rate based upon health factors. Health factors include: health status, medical condition (including both physical and mental illness), claims experience, receipt of health care, medical history, genetic information, evidence of insurability (including conditions arising out of acts of domestic violence and participation in activities such as motorcycling, snowmobiling, all terrain vehicle riding, horseback riding, skiing and other similar activities), and disability. This Section 4.6 shall not be read to prohibit the Plan from establishing more favorable rules for eligibility or premium rates for individuals with an adverse health factor such as disability.

The Plan shall not require a Covered Person or Dependent to pay a premium or contribution that is greater than a premium or contribution for a similarly situated individual enrolled in the Plan on the basis of any health factor. Notwithstanding the preceding, this Section 4.6 shall not be read to prohibit the Plan from providing a reward based upon adherence to a program of health promotion and disease prevention.

The Plan shall not adjust premiums or contributions based on genetic information, request or require employees or their dependents to undergo genetic testing, or request or require genetic information for underwriting purposes before enrollment.

ARTICLE 5—ELIGIBILITY

- 5.1 “Eligibility Requirements” Each Michigan Health Ministry of Ascension Health maintains its own eligibility requirements for an Employee to qualify for Plan coverage as specified in the Participating Employer’s Joinder Agreement. (See Addendum 1.) All other definitions of eligibility are standardized. The provisions of Addendum 1 shall control in determining who shall be eligible to participate unless the provisions of the Addendum do not address the individual’s circumstances, in which case, the provisions of Article 5 and 6 shall control.
- 5.2 “Dependent Eligibility” Family members who are dependent on an Eligible Employee may also be eligible for coverage under the Plan.

A. “Eligible Dependent” under *SmartHealth* is an Eligible Employee’s:

1. spouse (unless legally separated);
2. Child who is not currently married and who has not reached the end of the calendar year in which she turns age 19;
3. stepchild who resides with the Employee, according to the IRS definition, and is claimed as a dependent on the most recent federal income tax return;
4. Child who must be provided health coverage under the Plan as required by a Qualified Medical Child Support order (see Section 14.13);
5. Child who has not yet reached the end of the month in which she turns 25, who is not currently married, who is enrolled as a full-time student (at least 12 credit hours per semester or as defined by the educational institution) at an accredited college or other institute of higher learning and who is eligible to be claimed as a dependent on the Employee’s most recent federal income tax return (see Section 14.14);

6. Child who, before age 19 (or between age 19 and 25, if a full-time student), is totally and permanently disabled by a medically determined physical or mental condition that prevents her from being self-supporting, and who is dependent on the Employee for support and care.
- B. "Child" includes the Employee's natural child, legally adopted child, child placed with the Employee in anticipation of the child being adopted, foster child, stepchild, or child by virtue of legal guardianship. In connection with a Qualified Medical Child Support Order, the Child will be eligible for coverage even if the Child is born out of wedlock, is not claimed by the Employee as a dependent for federal income tax purposes, or does not reside with the Employee. In connection with any adoption or placement for adoption, Child means an individual who has not attained the age of 18 as of the date of such adoption or placement for adoption.
 - C. Employees will be required to provide proof (at the discretion of the Participating Employer) that the dependent is an Eligible Dependent to the local Human Resource/Benefits Department upon enrollment. Employees must notify the Plan Administrator within 30 days if any status change occurs which would result in a dependent no longer being eligible for Plan participation.

(However, notice of divorce or a Child's independence must be given within 60 days to be eligible for COBRA Continuation Coverage.) Any payments made by the Plan on behalf of an individual who is no longer an Eligible Dependent can be recouped from the Employee by the Plan (see Section 14.4, Overpayments).
 - D. An Eligible Dependent's coverage will end on the date the Employee's coverage ends or the individual no longer otherwise qualifies as an Eligible Dependent.

5.3 "Special Rules Regarding Double Eligibility"

- A. If an Employee and Spouse are both Employees and/or retirees of a Participating Employer, both Employees may each maintain their own individual coverage or may elect coverage with one Employee as the Eligible Employee and the other person covered as dependent Spouse.
- B. An Eligible Employee's Child cannot be an Eligible Dependent if the Child is employed by a Participating Employer and eligible for benefits under this Plan as an Employee as set forth in Section 5.1. If both the Employee and spouse work for a Participating Employer, only one of them can cover the Child as a Covered Person.

ARTICLE 6—PARTICIPATION

- 6.1 "Participation" An Eligible Employee becomes a participant in the Plan upon completion of enrollment forms as specified in Section 6.2, and her Eligible Dependents become beneficiaries when the Employee, as a participant, enrolls them in the Plan as Covered Dependents.
- 6.2 "Initial Enrollment Period" When an Employee first becomes eligible to enroll in *SmartHealth*, the Home Ministry's Human Resources/Benefits Department will provide the Eligible Employee with an enrollment package, that states of steps required to enroll in *SmartHealth*,

including:

- A. An explanation of choices to be made and the Employee contributions required for the benefits, if elected;
- B. The forms, or online address for access to the forms that must be completed to make elections for the Employee and Eligible Dependents, if any.
- C. An explanation of any wellness steps, if applicable, such as completion of a health risk assessment questionnaire, that are required as part of the on-line enrollment process.
- D. The deadline date for making elections for the Initial Enrollment Period, and an explanation of the next opportunity to enroll if elections are not made by the deadline date.

6.3 “Open Enrollment Period” An Eligible Employee can choose or change participation in *SmartHealth* during the Open Enrollment Period established by the Participating Employer each year for the following Plan Year. Written explanations provided to the Employee before the Open Enrollment Period will clearly describe the contributions for the benefits, if elected.

- A. The choices made under *SmartHealth* during the Open Enrollment Period will be effective as of the first day of the upcoming Plan Year.
- B. Once payroll deductions have started, the choices remain effective, without any changes permitted, until the next Plan Year or until the Employee has a Change Event. This provision shall apply unless the Home Ministry’s Section 125 cafeteria plan has a more restrictive provision regarding changes in choices after the end of the Open Enrollment Period, in which case the more restrictive provision shall apply.
- C. If an Employee does not enroll during the Open Enrollment Period, she must wait until the next Open Enrollment Period, Special Enrollment Period or Change Event to enroll in the Plan.

6.4 “Failure to Enroll” An Eligible Employee’s failure to timely enroll herself and any Eligible Dependents means that the Employee and Eligible Dependents will not have coverage under the Plan.

6.5 “Special Open Enrollment Period” An Eligible Employee may change elections or enroll herself and any Eligible Dependents in *SmartHealth* coverage other than during the Initial Enrollment Period or the annual Open Enrollment Period (or after a Change Event), if she declined coverage for herself or any Eligible Dependents under this Plan when first available because she or they were enrolled in other health coverage, but have since lost that coverage on account of having:

1. exhausted COBRA continuation coverage;
2. lost eligibility for the other coverage; or
3. employer contributions towards the other coverage terminated.

In this circumstance, the Employee may enroll herself and any Eligible Dependents in the Plan or make other changes on or before the 30th calendar day following the date the other coverage was exhausted or terminated. If the Employee or Eligible Dependents were not

provided with a Certificate of Creditable Coverage on or before the date the other coverage was exhausted or terminated, the Special Enrollment Period will end 30 days after the earlier of the date a Certificate of Creditable Coverage is provided for the previous exhausted or terminated coverage or the date that is 44 days after that coverage ceases.

If the Employee initially declined enrollment in *SmartHealth* for herself or Eligible Dependents and she later has a new Eligible Dependent as a result of marriage, birth, adoption or placement for adoption, she may also enroll herself and her Eligible Dependents (including those who are not the new Eligible Dependent) in this Plan, provided that the Employee requests enrollment on or before the 30th calendar day following the marriage, birth, adoption or placement for adoption. These 30-day periods are "Special Open Enrollment Periods". Any oral or written request to the Home Ministry's Human Resources/Benefits Department will be treated as a request for Special Enrollment. Election changes related to a birth, adoption or placement for adoption will take effect as of the date of the birth, adoption or placement for adoption. Election changes related to the Employee's marriage will take effect as soon as possible after the Employee requests enrollment.

6.6 "Change Events" An Employee cannot change her elections during the Plan Year, unless she experiences a Change Event and the requested change is consistent with the Change Event.

- A. *SmartHealth* elections may be changed if the Employee, spouse or dependent becomes eligible or ineligible for coverage on account of a change in:
1. legal marital status (e.g., marriage, divorce, legal separation, annulment);
 2. number of dependents (e.g., birth, death, adoption, placement for adoption);
 3. employment status (e.g., termination or commencement of employment);
 4. work schedule (e.g., part-time, full-time);
 5. residence (causing a change in coverage);
 6. a dependent satisfying or ceasing to satisfy requirements for unmarried dependents;
 7. coverage made by the Employee's spouse or dependent permitted under the spouse's or dependent's employer's benefit plan due to a Change Event;
 8. benefit options or coverage (addition or removal) available under *SmartHealth* (e.g., an HMO is added);
 9. an election made by the Employee's spouse or dependent during an open enrollment period under the spouse's or dependent's employer's benefit plan, which relates to a period that is different from the Plan Year for *SmartHealth*;
 10. the cost of coverage (a significant increase or decrease) during the Plan Year;
or
 11. the Employee, spouse or other Dependent becomes eligible for continuation coverage under COBRA or USERRA;

12. a judgment, decree or order, resulting from a divorce, legal separation, annulment, or change in legal custody (including a Qualified Medical Child Support Order) is entered by a court of competent jurisdiction that requires accident or health coverage for the Employee's Child;
 13. the Employee, spouse or dependent becomes enrolled under Part A or Part B of Medicare or under Medicaid (other than coverage solely with respect to the distribution of pediatric vaccines); or
 14. the Employee, spouse or dependent are eligible for a Special Open Enrollment Period.
- B. "Consistency Rule" Election changes must be consistent with the Change Event that affects coverage under *SmartHealth*. For example:
1. if one of the Employee's Covered Dependents no longer qualifies as an Eligible Dependent, the Employee may cancel coverage for that dependent, but may not cancel coverage for other Covered Dependents;
 2. if the dependent care provider changes under a Dependent Care Reimbursement Program, the Employee may change elections under the Dependent Care Reimbursement Program, but may not change *SmartHealth* elections; or
 3. if the Employee has single coverage and marries, she may elect family coverage.
- C. To change an election mid-year because of one of these Change Events, the Employee must submit a written request to the Home Ministry's Human Resources/Benefits Department and identify the event which resulted in the change. The request must be filed within 30 calendar days after the Change Event. If the Change Event is a birth, adoption, or placement for adoption, the election change will be effective as of the date of the Change Event, even though the change request is filed at a later date. For all other Change Events, the election change will take effect as soon as administratively possible after the request is filed.
- D. If the request is filed more than 30 days after the Change Event, no changes will be made to the Employee's elections or contributions, but she may make the necessary change during the next Open Enrollment Period for the following Plan Year.
- 6.7 "End of Participation" An Employee's participation (and any Covered Dependent's participation) in *SmartHealth* and her pay period deductions end at 11:59 p.m. on the earliest of the following dates:
- A. The last day of the month in which employment is terminated. Coverage may be continued, however, at the former Employee's cost, for limited periods of time (see COBRA Continuation Coverage). Different rules may apply in the event of salary continuation or severance payments.
 - B. The last day of the month of a change to ineligible status of the Employee or Dependent.
 - C. The last day of the calendar year in which the Dependent Child of the Employee attains the age of 19.

- D. The last day of the month in which the Dependent Child of the Employee who is a full-time student attains the age of 25.
 - E. The date of termination of *SmartHealth* by the Plan Sponsor or the date of withdrawal from *SmartHealth* by the *Participating Employer*.
- 6.8 **“Reinstatement”** If, during the same Plan Year, the Employee terminates employment and returns to employment within 30 days, elections prior to termination of employment will be reinstated automatically. If, during the same Plan Year, the Employee terminates employment and is rehired, but after 30 days, the Employee will be treated as a new hire (see Initial Enrollment Period, Section 6.2). Notwithstanding the provisions of this Section 6.8, if the Participating Employer has a different rule for reinstatement, that rule will govern.
- 6.9 **“Termination for Cause”** Notwithstanding anything in this Plan to the contrary, an Employee's and/or Dependent's coverage shall terminate at 11:59 p.m. on the last day the individual is qualified as a Covered Person as a result of termination of coverage by the Plan Administrator in its sole and absolute discretion with notice for just cause. Just cause shall include but is not limited to submission of fraudulent claims, refusal to follow a Physician's treatment plan (subject to a grievance procedure ruling if the Participant so requests), gross or repeated misbehavior including but not limited to abusive behavior toward health care providers or administrative staff in applying for or seeking any benefits under the Plan, failure to pay any required payments or Deductible amounts which are the responsibility of the Participant and the misuse of any Participant materials.

ARTICLE 7—EMPLOYER AND EMPLOYEE CONTRIBUTIONS

- 7.1 **“Payment of Required Employee Contributions”** The Participating Employer contributes to the cost of coverage for the Medical benefits under *SmartHealth*. The Employee must make contributions, which may be made on a pre-tax basis, for a share of the cost of these benefits.
- A. The Employee contributions are established at the discretion of the Participating Employer.
 - B. In order to elect coverage for a spouse who is eligible for medical benefits under the spouse's employer's health plan(s), the Employee may be required to comply with either a “spousal access” or “spousal surcharge” provision, as specified in the Health Ministry's Addendum 1.
 - C. The explanation of these contributions, which will be stated in enrollment information provided by the Employee's Home Ministry's Human Resources/Benefits Department along with an explanation of out-of-pocket costs that are also required, are hereby incorporated by reference.
- 7.2 **“Participating Employer's Contribution”** Each Participating Employer shall make contributions necessary to pay for the benefits provided under this Plan given the contributions made under Section 7.1. All contributions made by a Participating Employer, as provided for in this Plan, shall be determined separately by each Participating Employer, and shall be paid for the benefit of the Covered Persons subject to all the terms and conditions of this Plan. On the

basis of the information furnished by the Employers to the Plan Administrator, the Plan Administrator shall keep separate books and records concerning the affairs of each Participating Employer hereunder and as to the accounts and credits of the Employees of each Participating Employer. The Plan Administrator may, but need not, register contracts so as to evidence that a particular Participating Employer is the interested Employer hereunder, but in the event of an Employee transfer from one Participating Employer to another, the employing Participating Employer shall immediately notify the Plan Administrator thereof.

- 7.3 "Benefits from the Employer Assets" Plan benefits will be paid from the assets of the Participating Employers. Employee contributions will be held in accordance with ERISA Technical Release 92-01.

ARTICLE 8—COBRA CONTINUATION COVERAGE

- 8.1 "Qualifying Event" Under the Consolidated Omnibus Budget Reconciliation Act of 1985, as amended ("COBRA"), COBRA Continuation Coverage is available if a Covered Person's enrollment in *SmartHealth* would otherwise end on account of a life event known as a Qualifying Event. After a Qualifying Event, the Plan Administrator will offer COBRA Continuation Coverage to each person who is a Qualified Beneficiary.
- 8.2 "Qualified Beneficiary" A Qualified Beneficiary is someone who will lose coverage under the Plan because of a Qualifying Event.
- A. The Employee will become a Qualified Beneficiary if she will lose coverage under the Plan because one of the following Qualifying Events happens:
1. The Employee's hours of work are reduced or she moves to a position with the Participating Employer where she is not eligible to participate in the Plan;
 2. The Employee fails to return to work following a FMLA-qualified leave; or
 3. Her employment ends for any reason other than gross misconduct.
- B. The Employee's spouse will become a Qualified Beneficiary if coverage will be lost because any of the following Qualifying Events happens:
1. Any of the Qualifying Events listed in Section 8.2.A
 2. The Employee dies;
 3. The Employee becomes enrolled in Medicare (Part A, Part B, or both); or
 4. The Employee becomes divorced or legally separated from the spouse.
- C. A Covered Dependent Child will become a Qualified Beneficiary if she will lose coverage under the Plan because any of the following Qualifying Events happens:
1. Any of the Qualifying Events listed in Section 8.2.B, or
 2. The Employee's Child stops being eligible for coverage under the Plan as a dependent Child.

- D. Sometimes, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a Qualifying Event. If the employer commences a bankruptcy proceeding, and the bankruptcy results in the loss of coverage for retired employees, then the filing of the bankruptcy proceeding is a Qualifying Event for those retirees and any of their Covered Dependents who also lose coverage.

8.3 "Notice Required" The Plan offers COBRA Continuation Coverage to Qualified Beneficiaries only after the Plan Administrator has been notified that a Qualifying Event has occurred.

- A. When the Qualifying Event is the end of employment or a reduction of hours of employment, death, or enrollment in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the Qualifying Event within 30 days of any of these events.
- B. For the other Qualifying Events (divorce or legal separation or a dependent Child's losing eligibility for coverage as a dependent Child), the Employee must notify the employer in writing. Coverage cannot continue unless the employer is notified within 60 days after the latest of: (1) the date of the Qualifying Event; (2) the date on which there is a loss of coverage under the Plan; or (3) the date on which the Employee is informed through receipt of a Summary Plan Description of this Plan of the Employee's obligation to provide such notice to the Employee's Home Ministry's Human Resources/Benefits Department. The Employee's notice must include: the name of the employee or former employee who is or was a Plan participant; a description of the Qualifying Event; the date of the Qualifying Event; any documents or materials relevant to the Qualifying Event; and the name(s), address(es), and Social Security number(s) of the family members involved in the Qualifying Event. Failure of the Employee to notify her Home Ministry's Human Resources/Benefits Department in a timely manner will mean that she will not be able to elect COBRA Continuation Coverage for these Qualifying Events.

Once the Home Ministry's Human Resources/Benefits Department receives notice that a Qualifying Event has occurred, the Covered Person(s) will be notified about their right to continue coverage, or, if it is determined that the Covered Person(s) do not qualify for such coverage, she will be provided notice explaining why COBRA Continuation Coverage was denied. If the Covered Person(s) want to continue coverage, she must elect to do so on or before the date that is 60 days after the date the notice was sent. Each Covered Person can individually decide whether or not to continue coverage. Spouses may elect coverage for each other, but cannot reject coverage for the other person. Parents may elect to continue coverage on behalf of their dependent children, and may reject coverage for their minor children.

- C. The notice shall inform the Covered Person(s) that, in considering whether to elect COBRA Continuation Coverage, she should take into account that a failure to continue group health coverage will affect the following future rights under federal law. First, she can lose the right to avoid having pre-existing conditions exclusions apply to her by other group health plans if she has more than a 63-day gap in health coverage, and election of COBRA Continuation Coverage may help her not have such a gap. Second, she will lose the guaranteed right to purchase individual health insurance policies that do not impose such pre-existing condition exclusions if she does not get Continuation Coverage for the maximum time available to her. Finally, she should take into account that she has special enrollment rights under federal law.

She has the right to request special enrollment in another group health plan for which she is otherwise eligible (such as a plan sponsored by her spouse's employer) within 30 days after her group health plan coverage ends because of the Qualifying Events listed above. She will also have the same special enrollment right at the end of COBRA Continuation Coverage if she elects COBRA Continuation Coverage for the maximum time available to her.

- 8.4 "Premium Payments" COBRA Continuation Coverage is at the Covered Person's expense. The monthly cost of this continued coverage will be included in the notice but shall not exceed 102% of the cost to the Plan for *SmartHealth* coverage, depending upon the selected coverage, (including both the employer's share and the Employee's share of the cost) for a similarly situated Plan participant and/or beneficiary who is not receiving COBRA Continuation Coverage (or, in the case of an extension of COBRA Continuation Coverage due to a disability, 150%). If eligible for COBRA Continuation Coverage because employment terminated or hours of work are reduced, the Covered Person must pay COBRA premiums on an after-tax basis.

The notice will also specify the date by which the first premium payment must be received in order for coverage to continue. (Normally, this date will be 45 days after COBRA Continuation Coverage is elected. This is the date the election notice is post-marked, if mailed.) If the Covered Person does not make the first payment for COBRA Continuation Coverage in full not later than 45 days after the date of her election, she will lose all continuation rights under the Plan. The Covered Person is responsible for making sure that the amount of the first payment is correct.

Finally, the notice will specify the premium due date by which the Covered Person will be required to make monthly payments for each subsequent coverage period. There is a 30-day grace period for these monthly premiums. If they are not paid on or before the date that is 30 days after their due date, COBRA Continuation Coverage will end as of the first day of that period of coverage and cannot be reinstated. If a partial premium payment is made that falls short of the current amount due by a minimal amount, the Covered Person will be notified, and, if the shortfall is not paid on or before the date that is 30 days after the date the notice is received, COBRA Continuation Coverage will end as of the first day of that monthly period of coverage.

- 8.5 "Duration of Coverage" COBRA Continuation Coverage for the Employee as a Covered Person and/or her Covered Dependents may continue:

- for 18 months when the Qualifying Event is the Employee's end of employment or reduction of hours of employment;
- for 29 months when the Qualifying Event is the Employee's end of employment or reduction of hours of employment and the Employee or a Covered Dependent qualify for a disability extension (refer to "Disabled Individuals," below) during the 18-month COBRA Continuation Coverage period;
- for Covered Dependents, for a total of 36 months when the Qualifying Event is the Employee's divorce or legal separation, death, enrollment in Medicare (Part A or Part B), or the dependent Child's loss of dependency status; or
- for Covered Dependents, when the Qualifying Event is the Employee's end of employment or reduction of hours of employment, and the Employee is

enrolled in Medicare less than 18 months before the Qualifying Event, until 36 months after the date the Employee enrolled in Medicare (for example, if the Employee enrolled in Medicare 8 months before she terminated employment, COBRA Continuation Coverage for her Covered Dependents could last up to 36 months from the date she enrolled in Medicare, which is equal to 28 months (36 months minus 8 months) after the date of the Qualifying Event).

COBRA Continuation Coverage will be terminated before the end of the maximum period if:

- a premium payment was due but not timely paid;
- after the date of her election of COBRA Continuation Coverage, the person electing Continuation Coverage first becomes covered under another employer's group health plan that does not contain any exclusion or limitation that affects coverage of the covered individual's pre-existing condition;
- after the date of her election of COBRA Continuation Coverage, the person electing Continuation Coverage first becomes enrolled in Medicare coverage, whether Part A or Part B; or
- the Participating Employer terminates all of its group health plans.

8.6 "Newborns and Adopted Children" If the Employee as Covered Person or spouse elect COBRA Continuation Coverage, any Child born to or adopted by the Employee and spouse during the period of Continuation Coverage will also be a Qualified Beneficiary, and be entitled to Continuation Coverage for the maximum period of coverage available to any family member.

8.7 "Second Qualifying Event" If COBRA Continuation Coverage was elected by a Covered Dependent because the Employee's employment ended or hours were reduced and if, during the period of Continuation Coverage, another event occurs which is itself a condition for availability of Continuation Coverage, the maximum period of Continuation Coverage for the Covered Dependent may be extended for up to an additional 18 months (that means, to a maximum of 36 months from the date employment ended or hours were reduced) if notice of the second Qualifying Event is properly given to the Plan. This extension is available to the spouse or dependent Children if the Employee dies, enrolls in Medicare or is divorced or legally separated. This extension is also available to a dependent Child when the Child is no longer an Eligible Dependent. Continuation Coverage will still end, however, for any of the other reasons listed above, such as failure to pay premiums when due, *etc.*

The Covered Dependent must notify the Home Ministry's Human Resources/Benefits Department in writing of this second Qualifying Event within 60 days after the second Qualifying Event. The notice must include: the name of the employee or former employee who is or was a Plan participant; a description of the second Qualifying Event; and the name(s), address(es) and Social Security number(s) of the family members involved in the second Qualifying Event.

8.8 "Disabled Individuals" When the Qualifying Event for COBRA Continuation Coverage is the Employee's termination of employment or reduction in hours of employment, the 18-month period of COBRA Continuation Coverage may be extended by an additional 11 months (to a total of 29 months) if any of the Qualified Beneficiaries is determined by the Social Security Administration to be disabled. The disability has to have started before the 60th day of COBRA Continuation Coverage and must last at least until the end of the 18-month period of

COBRA Continuation Coverage. A Covered Person must notify the Home Ministry's Human Resources/Benefits Department in writing on or before the 60th day after the latest of: (1) the date of the Social Security Administration's disability determination; (2) the date on which the employment-related Qualifying Event occurred; (3) the date on which the Qualified Beneficiary loses Plan coverage; or (4) the date on which the Qualified Beneficiary is informed of the obligation to provide the disability notice. This disability notice must include the name of the disabled person, the effective date of the Social Security Administration's disability determination, and any accompanying documentation.

In addition, if the disabled covered individual is finally determined **not** disabled by the Social Security Administration, then she, or another person, must notify the Home Ministry's Human Resources/Benefits Department in writing no later than 30 days after the date of such a determination. This disability notice must include the name of the formerly disabled person, the effective date of the Social Security Administration's determination that she is no longer disabled, and any accompanying documentation. The 11-month disability extension of COBRA Continuation Coverage will end on the first day of the month following the date the Qualified Beneficiary is determined not to be disabled. Continuation Coverage due to the initial employment-related Qualifying Event, or any subsequent Qualifying Event, may still be available if the maximum period for such Continuation Coverage has not expired as of the date a determination of "no longer disabled" is made.

The cost of Continuation Coverage for the 11-month disability extension will, however, increase after the 18th month of Continuation Coverage, unless coverage would continue in any event on account of a second Qualifying Event. The increase, if any, will not exceed 150% of the cost to the Plan, including both employer and employee contributions, for coverage of a similarly situated plan participant or beneficiary who is not receiving Continuation Coverage.

- 8.9 "Individual Coverage" Under the Plan, the Employee as a Covered Person has the right, when group health plan coverage ends, to enroll in an individual health insurance policy, without providing proof of insurability. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. This right may be exercised in lieu of electing COBRA Continuation Coverage, or after having received the maximum COBRA Continuation Coverage available. However, by enrolling in an individual conversion policy, the Covered Person loses the right under federal law to purchase individual health insurance that does not impose any pre-existing condition limitations when the conversion policy ends
- 8.10 "Trade Act" Former Employees who are eligible for trade adjustment assistance under the Trade Act of 2002, or are at least age 55 and receiving a pension benefit from the Pension Benefit Guaranty Corporation, may be eligible to take a tax credit or get advance payment of up to 65% of the COBRA Continuation Coverage premiums. In certain circumstances, they may also be eligible for a second 60-day COBRA election period.
- 8.11 "Questions about COBRA Continuation Coverage" If a Covered Person has questions concerning the Plan or COBRA Continuation Coverage rights, she should contact the Plan Administrator. For more information about rights under ERISA (including COBRA), the Health Insurance Portability and Accountability Act (HIPAA), and other laws affecting group health plans, the Covered Person may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website

at www.dol.gov/ebsa. The Covered Person may, of course, also contact the Home Ministry's Human Resources/Benefits Department or the Plan Administrator .

- 8.12 "Keep the Plan Informed of Address Changes" The Covered Person, in order to protect her family's rights, should keep the Plan Administrator informed of any changes in the addresses of family members. A copy of all notices sent to the Plan Administrator should also be kept.

ARTICLE 9—USERRA CONTINUATION COVERAGE

- 9.1 "Continuation Coverage If Called to Active Duty" If a Covered Person is called to active duty in the United States Armed Forces (including the Coast Guard), the National Guard or the Public Health Service, she will be offered, under the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"), up to 24 months of continuation coverage.
- A. If the leave is less than 31 days, the Employee will have to make the same contributions towards coverage as do active employees, but cannot be required to contribute more than that amount.
 - B. If the leave is longer than 31 days, then 102% of the total premium may be charged for the coverage.
 - C. The maximum period for continuation coverage under USERRA is the lesser of:
 - 1. 24 months from the date the leave commences or;
 - 2. the period from the date the leave begins to the day after the Employee fails to return to employment within the time allowed following discharge (for leaves less than 31 days, 1 day is allowed; for leaves 31-180 days, 14 days are allowed; for leaves longer than 180 days, 90 days are allowed).
- 9.2 "Alternate Coverage" The continuation coverage mandated under USERRA is alternate coverage to that provided under COBRA, so the two coverage periods run concurrently, not consecutively. Eligibility for TRICARE (formerly CHAMPUS) or active duty military coverage will not terminate coverage under this continuation coverage.

ARTICLE 10—HEALTH INFORMATION SAFEGUARDS

- 10.1 "Privacy Rule" HIPAA and the Standards for Privacy of Individually Identifiable Health Information require health plans to protect the confidentiality of a Covered Person's Protected Health Information. This "Privacy Rule" applies to *SmartHealth*. A description of rights under the Privacy Rule and HIPAA can be found in the Notice of Privacy Practices, which is provided to all Employees and is available from the Home Ministry's Human Resources/Benefits Department.
- 10.2 "Business Associates" As part of the Privacy Rule, *SmartHealth* may use and disclose a Covered Person's Protected Health Information as permitted or required by the Privacy Rule .

SmartHealth has also required all its service providers (“Business Associates”) that create, receive or maintain Protected Health Information to comply with the Privacy Rule.

- 10.3 “Protected Health Information” “PHI” includes any information, whether oral or recorded, in any form or medium, that is created or received by the Plan relating to a Covered Person’s past, present, or future physical or mental health, including the provision of and payment for care, that identifies or provides for a reasonable basis for identification of the Covered Person. PHI does not include de-identified health information or health information that the employer is entitled to under applicable law (e.g., FMLA, Occupational Safety Health Administration, Americans with Disabilities Act, worker’s compensation and other state and federal laws), or that the employer obtains through sources other than the Plan and retains as part of a Covered Person’s employment records (e.g., drug screening tests, fitness for duty examination results or other similar information). This type of information is not subject to the Privacy Rule.
- 10.4 “Privacy Officer” As part of its efforts to comply with the HIPPA Privacy Rule, the Plan has appointed a Privacy Officer. The Privacy Officer is the person with whom a Covered Person should lodge any complaints if she believes that the confidentiality of herself or her Covered Dependents has been compromised in the course of administering benefit claims. The HIPPA Privacy Officer for the Plan is the Plan Sponsor’s Benefits Consultant.
- 10.5 “Required Disclosures of PHI by the Plan” The Plan must disclose a Covered Person’s PHI under the following three conditions:
- to the Covered Person with respect to her own PHI;
 - to the Secretary of the Department of Health and Human Services to determine whether the Plan is in compliance with the Privacy Rule; and
 - where required by law. This means that the Plan will make the disclosure only when the law requires it to do so, but not if the law would just allow it to do so.
- 10.6 “Permitted Uses and Disclosures of PHI by the Plan” The Plan may use or disclose a Covered Person’s PHI as necessary for the operation of the Plan as described in this document and under the following conditions:
- for treatment purposes, when necessary;
 - to Business Associates that enter into Business Associate Agreements with the employer;
 - under certain circumstances expressly permitted by the Privacy Rule;
 - to the Covered Person about treatment alternatives or health-related benefits or services that may be of interest to the Covered Person; or
 - with a proper authorization from the Covered Person.
- 10.7 “Payment and Health Care Operations” The Plan may use or disclose the Covered Person’s PHI for Payment purposes or for Health Care Operations.
- A. “Payment” includes activities undertaken by the Plan to obtain contributions or to determine and fulfill its responsibilities for the provision of benefits under the Plan, including:

- determinations of eligibility or coverage, including coordination of benefits with other health plans;
- disclosure to Physicians of eligibility for coverage and the percentage or amount of the bill the Plan might pay;
- adjudication or subrogation of health benefit claims;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities;
- obtaining payment under a contract of reinsurance, including stop-loss or excess loss insurance whether obtained with respect to the direct payment obligation of the Plan or the indirect contribution obligation of SJHS for benefits under the Plan (and related health care data processing);
- review of health care services with respect to medical necessity, coverage under the Plan, appropriateness of care, and justification of charges;
- utilization review activities, including Prior Authorization, concurrent and retrospective review;
- disclosure to consumer reporting agencies of the following PHI items related to the collection of contributions or reimbursements:
 - the Covered Person's name and address, date of birth, Social Security number, payment history, account number; and
 - the name and address of health care provider and/or this Plan.

B. "Health Care Operations" cover a wide range of activities, including:

- quality assessment activities;
- reviewing the qualifications of health care professionals;
- underwriting, premium writing and other activities relating to creating, obtaining, or renewing health insurance or health benefits, including a contract of reinsurance or stop-loss insurance obtained in connection with the provision of Plan benefits either directly or indirectly;
- conducting or arranging for medical review, legal services, and auditing functions including fraud and abuse detection and any regulating compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of methods of payment or providing benefits; and
- creating de-identified information or limited data sets, if needed, for Plan administration.

10.8 "Uses and Disclosures of PHI Expressly Permitted by the Privacy Rule" The Privacy Rule permits the Plan to use or disclose the Covered Person's PHI as follows:

- as required by law (i.e., the state or federal law requires, and does not merely permit, the Plan to make the disclosure);

- for public health purposes;
- to report information about victims of abuse, neglect or domestic violence;
- for health oversight activities;
- for judicial and administrative proceedings pursuant to judicial or administrative orders or where the Plan has received adequate assurances (as provided in the Privacy Rule), that the PHI disclosed will remain confidential;
- for certain law enforcement purposes as set forth in the Privacy Rule;
- to correctional facilities regarding inmates;
- to report information about decedents to funeral directors, coroners and medical examiners;
- for purposes of cadaveric organ, eye or tissue donation;
- for use in a limited data set for purposes of research, public health or health care operations, if a data use agreement has been signed;
- for research purposes;
- to avert a serious threat to health or safety;
- for emergencies and disaster relief;
- for specialized governmental functions (e.g., national security or defense);
- incidental disclosures, provided the Plan puts reasonable physical safeguards in place;
- to the Covered Person's personal representative, after receiving proof that she has authority to act on behalf of the Covered Person;
- to individuals involved in the Covered Person's care or payment for care, if the Plan provides the Covered Person the opportunity to object and she does not, or the Plan infers from the circumstances that she does not object; and
- for workers' compensation.

10.9 "Disclosure of PHI by the Plan's Workforce" The Plan may disclose the Covered Person's PHI to the Plan's Workforce to carry out Plan administrative functions because the Participating Employer agrees to the following provisions. These disclosures, however, will be made only to the Plan's Workforce. The employer agrees to:

- not use or further disclose the information other than as permitted or required by this Plan or as required by law;
- ensure that any agents, including a subcontractor to whom it provides PHI received from the Plan, agree to the same restrictions and conditions that apply to the employer with respect to such information;
- not use or disclose the information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the employer, except disclosures may be with respect to workers' compensation as described above;

- report to the Plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures provided under the Plan of which it becomes aware;
- make available to the Covered Person her PHI that is maintained by the Plan and provide her with the right to obtain a copy of her PHI disclosed to and retained by the employer;
- permit the Covered Person to amend her PHI maintained by the Plan and incorporate these amendments as required by the Privacy Rule;
- permit the Covered Person to have an accounting of the disclosures of her PHI made by the Plan as described in the following section entitled "Rights Under HIPPA and the Privacy Rule;"
- make its internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services for purposes of determining compliance with the Privacy Rule;
- if feasible, return or destroy all PHI received from the Plan that the employer still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and
- ensure that adequate separation between the Plan and the employer is established as described below.

The Plan's "Workforce" means those Health Ministry Human Resources/Benefits staff and appeals committee members with a business need to know.

The Plan and Participating Employers will take steps to provide for the adequate separation between the Plan and the employer. Only the Plan's Workforce will have access to the Covered Person's PHI. The Plan's Workforce will receive PHI, as needed, in the ordinary course of business, to carry out the payment, health care operation or other functions necessary for the proper operation of the Plan.

The Plan will restrict the access to, and use and disclosure of, the Covered Person's PHI by these employees to only those administrative functions that the Plan's Workforce performs for the Plan. The Plan may also disclose limited health information to the Plan's Workforce in connection with enrollment and disenrollment of individuals into or out of the Plan. The Plan Administrator will handle any complaint relating to non-compliance by addressing that issue with the employee. The Plan Administrator will also provide for a mechanism for resolving issues of noncompliance, including disciplinary action up to and including discharge.

To maintain the confidentiality of her PHI, the Covered Person should only communicate with one of these individuals if she wishes to inquire about any aspect of the Plan, a benefit claim, her entitlement to coverage or any other matter regarding her or her family's health care benefits under the Plan, and the matter she wishes to discuss requires that she share or communicate medical information about herself or her dependent covered under the Plan.

10.10 “Other Health Information” Health information obtained by Participating Employers through sources other than the Plan is not PHI (for example, FMLA medical certifications, Occupational Safety and Health Administration required medical evaluations, drug screening tests, fitness for duty examination results, or other types of similar information that may be retained as part of employment records) and, therefore, is not subject to the Privacy Rule or the restrictions described in this section of the Plan. Accordingly, the employers do not intend to treat this information as PHI.

10.11 “Rights under HIPAA and the Privacy Rule” Covered Persons have certain rights, under HIPAA and the Privacy Rule, relating to PHI maintained by the Plan, including the right to:

- access and copy the PHI;
- receive an accounting of disclosures of PHI made within the six year period before the request, other than those made for:
 - treatment, payment and Health Care Operations;
 - prior to April 14, 2003;
 - to the Covered Person or close family members involved in her care;
 - to law enforcement officers, correctional institutions (about inmates or for national security purposes);
 - incidentally to otherwise permitted disclosures;
 - as part of a limited data set; and
 - with the Covered Person’s express authorization.
- amend the Covered Person’s PHI, under certain circumstances;
- request restrictions on the permitted uses and disclosures of the Covered Person’s PHI;
- request confidential communications (e.g., sending information to an alternate address);
- file a complaint with the Plan’s Privacy Officer, the person named in an insurer’s Notice of Privacy Practices to receive complaints, or with the Secretary of the Department of Health and Human Services if the Covered Person believes her rights have been violated; and
- receive a copy of the Plan’s Notice of Privacy Practices.

All requests to exercise individual rights must be made in writing to the Covered Person’s Home Ministry’s Human Resources/Benefits Department or the Privacy Officer. The Plan’s Notice of Privacy Practices, contains a more detailed description of the Plan’s privacy procedures and rights under HIPAA. Covered Persons should contact the Home Ministry’s Human Resources/Benefits Department for more information or to receive a copy of the Notice of Privacy Practices.

A Covered Person who has questions about the status of her PHI or what is being done to protect its confidentiality, may contact the Privacy Officer. A Covered Person who wishes to file a complaint may contact her Home Ministry’s Human Resources/Benefits Department.

- 10.12 “Security Rule” HIPAA and the Standards for Security of Electronic Protected Health Information (the “Security Rule”) require health plans to protect the confidentiality, integrity, and availability of the Covered Person’s Electronic PHI (“EPHI”) that they create, receive, transmit, or maintain about the Covered Person in the course of providing health care benefits. To ensure the security of a Covered Person’s EPHI, the Participating Employers will comply with the Security Rule as set out below. The Plan has also required its Business Associates to agree to protect EPHI.

EPHI includes any PHI that is transmitted or maintained in an electronic media. “Electronic Media” includes media used to store EPHI such as a hard drive in a computer, as well as media used to transmit EPHI; for example, the Internet. The Security Rule does not cover EPHI that began or was originally created in Electronic Media before being electronically transmitted. For example, EPHI transmitted paper-to-paper, fax-to-tax, by messages containing EPHI left on voice-mail, through telephone calls, or by video conferencing is not covered by the Security Rule.

- 10.13 “Disclosures of EPHI Expressly Permitted by the Security Rule” The Security Rule permits the Plan to disclose a Covered Person’s EPHI to Participating Employers as follows:

- de-identified health information to the employer, if the employer requests the information for the purpose of obtaining premium bids from health plans for providing health insurance coverage under the Plan;
- de-identified health information to the employer, if the employer requests the information for the purpose of modifying, amending, or terminating the Plan;
- to the employer when the Covered Person authorizes the disclosure; and
- to the employer to determine enrollment or eligibility status in the Plan.

- 10.14 “Disclosures of EPHI by the Plan to the Employer” The Plan may disclose a Covered Person’s EPHI to the employer to carry out Plan administrative functions because the employer agrees to the following provisions. These disclosures, however, will only be made to the Plan’s Workforce. The employer agrees to:

- implement “Policies and Procedures” that reasonably and appropriately protect the confidentiality, integrity, and availability of the EPHI that it creates, receives, maintains, or transmits on behalf of the Plan;
- make any documentation related to the Policies and Procedures available to the Secretary of the United States Department of Health and Human Services for the purpose of determining the Plan’s compliance with the Security Rule;
- ensure that any agent, including a subcontractor, to whom it provides EPHI agrees to implement reasonable and appropriate security measures to protect the EPHI;
- report to the Plan any “Security Incident” of which it becomes aware, including an attempted or successful unauthorized access, use, disclosure, modification, or destruction of EPHI; and
- ensure that adequate separation between the Plan and the employer is established and described below.

The Plan and the Participating Employers will take steps to provide for the adequate separation between the Plan and the employers for purposes of exposure to EPHI. Only members of the Plan's Workforce will have access to a Covered Person's EPHI.

The Claims Administrator for Medical Benefits may receive EPHI related to a Covered Person's medical coverage in the ordinary course of its business. Any EPHI received by the Claims Administrator in the ordinary course of its business will be subject to the same Policies and Procedures provided to all customers and members.

ARTICLE 11—COORDINATION OF BENEFITS

11.1 "Coordination with Other Coverage" *SmartHealth* benefits will be coordinated with:

- another "Group Health Plan" (including any employer sponsored welfare benefit plan, whether or not insured, that provides medical coverage), such as insurance provided by a spouse's employer;
- motor vehicle accident insurance; and
- money a Covered Person could receive from another person or entity who caused the injuries on account of which a claim was made.

When the Plan coordinates benefits, one source of benefits will be "Primary" (that is, it will pay before the other source). The other source will be "Secondary" (that is, it will pay after the source of benefits that is Primary).

When the Plan is Primary, it will pay benefits as if there were no other source of benefits. But if the Plan is Secondary, it will first calculate what it would pay in the absence of any other source of benefits. Then the Plan will subtract from that amount the amount that should be paid by the other source. The Plan will pay that difference, so that the participant will receive the full amount of benefits payable under the Plan. (The amount payable by the other source will be subtracted even if the Covered Person does not apply for benefits from that other source.) This Plan will not, however, pay more than it would have if it were the only source of benefits.

11.2 "Coordination with Other Group Health Plans" If a Covered Person incurs an expense that would be paid by two or more Group Health Plans, the Group Health Plan with the highest priority is Primary and will pay first. The other Group Health Plan is Secondary and will pay next.

Benefits will be paid as follows, unless specified otherwise:

First: A Group Health Plan without a coordination of benefits provision will pay.

Second: Then a Group Health Plan covering the patient as an employee, rather than as a dependent, will pay.

Third: Then in the case of a Group Health Plan covering a patient who is a dependent and a minor Child of divorced or legally separated parents:

- if a divorce decree or separation agreement makes a parent responsible for a Child's health expenses, that parent's Group Health Plan (that also covers the Child) will pay.
- then a Group Health Plan that covers the Child as a dependent of a custodial parent will pay;
- then a Group Health Plan that covers the Child as a dependent of the spouse of the custodial parent will pay;
- then a Group Health Plan that covers the Child as a dependent of the non-custodial parent will pay.

Fourth: Then in the case of a Group Health Plan covering a patient who is a dependent and minor Child of married parents, the Group Health Plan of the parent whose birthday occurs earlier in the year will pay.

Fifth: Then in the case of a Group Health Plan covering a patient who is a dependent and minor Child of married parents, the Group Health Plan of the parent whose birthday occurs later in the year will pay.

Sixth: Then the Group Health Plan which has covered the patient for the longer period of time will pay.

Seventh: Then any other Group Health Plan will pay.

If two or more Group Health Plans have the same priority, they will each pay *pro-rata*.

11.3 **“Special Rules”** There are some special rules, however, which have precedence over the above priorities. They are:

- COBRA coverage is always Secondary to any other Group Health Plan.
- Coverage provided by virtue of being a retired or laid off employee or an employee on a leave of absence is always Secondary to coverage provided by virtue of that individual being an active employee, except that coverage provided by TRICARE (through the U.S. armed services) is always Secondary to any other employer sponsored Group Health Plan.

11.4 **“Coordination with Motor Vehicle Accident Insurance”** The Plan coordinates payment of its Self-funded health care benefits on a Secondary basis. Any state insurance law that purports to require the Plan to pay Primary or that does not allow the Plan to subrogate or recover its payments is preempted by ERISA.

A. This means that even if the Covered Person is covered under a motor vehicle insurance policy that makes “other health coverage” Primary, the Plan will still pay Secondary for those benefits which are Self-funded.

A Covered Person is considered covered under a motor vehicle insurance policy if she is:

- an owner or principal named insured under the policy; or
- a family member of a person insured under the policy; or

- a person who would be eligible for medical expense benefits under a motor vehicle insurance policy if this Plan did not exist.

B. If the Covered Person does not have motor vehicle insurance coverage:

- even though the Covered Person is legally required to do so, the Plan will not pay more benefits than it would have paid if the Covered Person had purchased standard motor vehicle insurance coverage.
- If the Covered Person does not have motor vehicle insurance coverage and is a passenger in a vehicle and the driver also does not have motor vehicle insurance coverage, this Plan will pay primary.

11.5 “Coordination with Medicare” The general rule is that the Plan will be Secondary to Medicare in all circumstances where federal law does not require the Plan to be Primary. If a Covered Person is covered under *SmartHealth* as an active employee and the Covered Person or spouse is over 65 years old and eligible for Medicare, the Covered Person may reject coverage in this Plan and rely on Medicare as the sole source of coverage. If the Covered Person does not reject coverage under this Plan, she will have coverage in both this Plan and Medicare, and Medicare will be Secondary. If the Covered Person is covered under *SmartHealth* as a retiree, and the Covered Person and spouse are over 65 years old and also covered under Medicare, Medicare will be Primary and the Plan will only pay for the reimbursement of Medicare deductible and coinsurance.

When Medicare is available for certain people who have not yet reached the age of 65, the Plan will be Primary as long as the Covered Person is in current employment status; otherwise the Plan will be Secondary.

The Plan will be Primary to Medicare for a Covered Person who qualifies for Medicare benefits because of end-stage renal disease for the coordination period set forth in the Medicare secondary payer provisions of the Social Security Act. After the coordination period ends, the Plan will be Secondary to Medicare and only pay Medicare deductibles and coinsurance.

If Medicare is Primary under these rules, the Plan will calculate the benefits it provides as if the Covered Person were enrolled in Medicare, regardless of whether she has applied.

11.6 “Coordination with Third Parties” If a third party negligently or tortiously causes a health problem on account of which the Covered Person has incurred medical expenses, the Plan is Secondary to the third party’s liability to the Covered Person. If benefits are available under any insurance policy as a result of this negligent or tortious conduct, the Plan is Secondary to those benefits.

11.7 “Facility of Payment” If an expense or benefit that should have been paid by the Plan is paid by another person or entity, the Plan may pay to that person or entity any amount that it considers necessary to satisfy the intent of these coordination provisions. The Plan will then have no further liability for those expenses or benefits.

11.8 “Subrogation; Right of Recovery” The Plan is designed to pay and will only pay those expenses for which payment is not available from another source including, but not limited to, any insurance company, group health plan or individual as an award, settlement, damages or otherwise. Any expenses for which payment is available from another source are not Covered

Expenses under the Plan. The Plan, however, may pay Covered Expenses that may be, or may become, the responsibility of another person, provided that the Plan is entitled to receive reimbursement for those payments. Any such payments are conditional, and are made on the basis that the Plan will be reimbursed in full from funds recovered from the other source.

- 11.9 “Assignment of Rights” By enrolling in the Plan, and applying for and accepting benefits from this Plan, the Employee as Covered Person and her Covered Dependents automatically assign to the Plan any rights she or they may have to recover all or part of the same Covered Expenses from another source, including another Group Health Plan, insurer, or an individual. By virtue of this assignment, the Plan is entitled to recover up to 100% of the Covered Expenses it has paid on behalf of the Employee as Covered Person or her Covered Dependents. This assignment allows the Plan to pursue any claim that she may have against a third party, or its insurer, whether or not the Covered Person chooses to pursue that claim. The Employee as Covered Person or her Covered Dependents cannot assign any rights or causes of action she or they may have against a third party, or its insurer, to recover medical expenses without the express written consent of the Plan Administrator.

Should a Covered Person elect to pursue a claim against a third party or its insurer, she is required to inform the Home Ministry’s Human Resources/Benefits Department or the Plan Administrator of the action and the forum in which it has been filed. The Covered Person is also obligated to keep the Plan Administrator informed of any developments in the case and any settlement efforts. Once the Covered Person has formally notified of the Plan’s subrogation and reimbursement interest in the Covered Person’s case (either by intervention before the court or by notice to the Covered Person’s attorney), the matter cannot be settled without the express written consent of the Plan Administrator. Should the Covered Person elect to not pursue a claim against a third party or its insurer, the Plan may do so in order to recover the medical expenses it paid on behalf of the Covered Person, and the Covered Person is required to cooperate with the Plan in the pursuit of its claim.

Should a Covered Person pursue a claim, the assignment to the Plan includes, without limitation, a right to any award, settlement, damages and funds or property paid by a third party to or on behalf of the Covered Person, and also includes, but is not limited to, the right to be reimbursed from funds paid to the Covered Person’s attorney, to any other individual entitled to receive any recovered amounts on the Covered Person’s behalf, and/or to a trust established on behalf of the individual as a result of the individual exercising her rights of recovery (“Recovered Funds”). This assignment entitles the Plan to be reimbursed on a first-dollar basis (i.e., to have a first priority claim to the Recovered Funds), whether the Recovered Funds paid to or for the benefit of the Covered Person amount to a full or partial recovery on her part, or whether the Recovered Funds are designated for non-medical or dental charges, attorney’s fees or other costs and expenses.

When the Covered Person, and not the Plan, pursues and obtains any recovery, the Covered Person will be responsible for all expenses involved in obtaining that recovery from any third party payer, whether by settlement or judgment, including, but not limited to, all attorneys’ fees and costs. These expenses will not reduce the amount the Covered Person is required to reimburse the Plan. This assignment also grants the Plan a right to recover from the Covered Person’s no-fault motor vehicle insurance carrier in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

- 11.10 “Equitable Lien and Other Equitable Remedies” By virtue of the Plan’s payment of Covered Expenses, the Employee as Covered Person and her Covered Dependents agree that the

Plan will have a first priority equitable lien against any Recovered Funds she or they recover from any party, including an insurer or another Group Health Plan, but only to the extent of the Covered Expenses that the Plan has paid. This equitable lien also attaches to any payment received from workers' compensation, whether by judgment or settlement, where the Plan has paid Covered Expenses prior to a determination that the Covered Expenses arose out of and in the course of employment. Payment by workers' compensation insurers will be deemed to mean that such a determination has been made. This equitable lien by agreement will also attach to any Recovered Funds. The Covered Person is required to segregate and maintain any Recovered Funds so that they are readily identifiable until the Plan's right of recovery has been perfected and the Plan reimbursed. The Plan will also be entitled to seek any other equitable remedy against any party possessing or controlling any Recovered Funds. At the discretion of the Plan Administrator, the Plan may reduce any future Covered Expenses otherwise available to the individual under the Plan by an amount up to the total amount of the Covered Expenses paid by the Plan that is subject to the equitable lien. The Plan's right to recover under Sections 11.8, 11.9 and 11.10 shall extend to the guardian and the estate of each Covered Person. The coordination of benefits provisions of Article 4 shall not apply to reduce the amount of Recovered Funds available to the Plan.

This and any other provisions of the Plan concerning equitable liens and other equitable remedies are intended to meet the standards for enforcement under ERISA enunciated in the United States Supreme Court's decision in *Great-West Life & Annuity Ins. Co. v. Knudson* (2002), as amplified by *Sereboff et ux. v. Mid-Atlantic Medical Services Inc.* (2006). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies shall supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

11.11 "Obligation to Assist in the Plan's Reimbursement Activities" If a Covered Person is involved in a motor vehicle accident, or suffers an illness or injury that may entitle her to recover from a third party, and the Plan advances payment, the Covered Person has an obligation to help the Plan obtain reimbursement for the amount of the payments it advanced. As part of this obligation, the Covered Person is required to provide the Plan with any information concerning any other applicable insurance coverage that may be available (including, but not limited to, motor vehicle, home, other liability insurance coverage, and coverage under another Group Health Plan), and the identity of any other person or entity, and their insurers (if known), and that may be obligated to provide payments or benefits on account of the same illness or injury for which the Plan made payments. The Covered Person is required to:

- cooperate fully in the Plan's exercise of its right to subrogation and reimbursement;
- not to do anything to prejudice those rights (such as settling a claim against another party without notifying the Plan or by not including the Plan as a co-payee);
- sign any document deemed by the Plan Administrator to be relevant in protecting the Plan's subrogation and reimbursement rights;
- maintain any Recovered Funds so that they are readily identifiable until the Plan's subrogation and/or reimbursement rights have been perfected and the Plan has been reimbursed; and
- provide relevant information when requested.

The term "information" here includes any documents, insurance policies, police or other investigative reports, as well as any other facts that may be reasonably requested to help the

Plan enforce its rights. Failure by the Covered Person to cooperate with the Plan in the exercise of these rights may result, at the discretion of the Plan Administrator, in a reduction of future benefit payments available to the Covered Person under the Plan of an amount, up to the aggregate amount paid by the Plan that was subject to the Plan's equitable lien, but for which the Plan was not reimbursed.

- 11.12 "Payments by Other Sources" The Plan will not pay any expense or benefit which has actually been paid by another source, even if that other source is Secondary to the Plan, unless that source files a claim for reimbursement. If the other source files a claim for reimbursement, the Facility of Payment provision (see above) of this Plan applies.
- 11.13 "Service Plans" If a Group Health Plan provides benefits in the form of services (e.g., the plan sponsor operates and provides medical care through a clinic) rather than cash payments, the reasonable cash value of each service provided is considered as paid by that Group Health Plan.
- 11.14 "Certificate of Creditable Coverage" documenting the nature and duration of Plan coverage will be sent by first class mail to the last known address of any Participant and spouse (and Dependent if living separately): (1) when the individual ceases to be covered under the Plan, and (2) if the individual elects COBRA Coverage, then again when COBRA Coverage ceases. In addition, an individual may request a Certificate of Creditable Coverage from the Plan Administrator anytime within a period of 24 months after the end of coverage (including COBRA Coverage).

"Creditable Coverage" is coverage under any of the following medical programs: this Plan, another group health plan, group or individual health insurance coverage issued by a state regulated insurer (including Blue Cross and Blue Shield or an HMO); Medicare Part A or Part B; Medicaid; the active military health program (TRICARE); an American Indian health care program; a state health benefits risk pool; a public health plan (as defined in the regulations under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA")) or the Peace Corps Health Program.

ARTICLE 12—CLAIMS AND CLAIMS REVIEW PROCEDURES

- 12.1 "Claims Administrator" For purposes of these claim filing and review procedures, the entity or individual that is responsible for determining a claim is always referred to as the "Claims Administrator." This reference applies to the Plan Administrator or a third party hired by the Plan Administrator. The Claims Administrator who reviews a denied claim may be different than the Claims Administrator who reviews the initial claim.
- 12.2 "Claim Procedures" The type of claim filed will determine the claim procedures and time periods for the decisions relating to these claims. In most cases, the Covered Person's doctor, pharmacist or other health care provider may file the claim on the Covered Person's behalf. In other cases, the Covered Person may have to submit a claim, and supporting documentation, if any, in order to have the claim paid.

The Covered Person's doctor, pharmacist or other health care provider with knowledge of the Covered Person's condition will be treated as a Covered Person's authorized representative. A Covered Person may also appoint an authorized representative, (using forms available

from the Home Ministry's Human Resources/Benefits Department), to deal with the Plan on her behalf with respect to any benefit claim that she files or any review of a denied claim that she chooses to pursue. Once the Covered Person has appointed an authorized representative, the Claims Administrator will communicate directly with that representative, and will not also inform the Covered Person of the status or outcome of the claim. The Plan will only recognize the person that the Covered Person has authorized on the last dated form filed with the Plan. If no representative is appointed, the Claims Administrator will communicate with the Covered Person directly. Claims may be filed and a review of any denied claim may be sought by any Covered Person or any properly authorized representative.

- 12.3 "Pre-Service Claims" A Pre-Service Claim is a claim that is not time-sensitive for a benefit under the Plan that is conditioned, in whole or in part, on obtaining advance approval of the benefit prior to obtaining the medical care. (Pre-Service Claims that are time-sensitive will be referenced as "Time-Sensitive Claims".)

With respect to any benefit that requires Prior Authorization, or any other step required under the Plan in order for the benefit to be paid, the Covered Person's request (or that of the authorized representative) for that benefit will be treated as a Pre-Service Claim (see Section 2.3.A Schedule of Medical Benefits and Section 2.7 Prior Authorization Requirements). The treating Physician, pharmacist, or other health care professional with knowledge of the Covered Person's condition will be treated as the Covered Person's authorized representative.

Pre-Service Claims may be made to: *SmartHealth* c/o St. John Health System-Managed Care, Attn: Pre-Service Claims, 28000 Dequindre, Warren, MI 48092-2468 or by facsimile (586-753-0981) or telephone (800-869-8388).

The Claims Administrator will respond within a reasonable time period appropriate to the circumstances, but in no case later than 15 days after receiving the claim, as follows:

- A. If a Pre-Service Claim has not been filed properly pursuant to the Plan's claim procedures, the Covered Person (or authorized representative) will be notified of that fact within 5 days, and will be told what steps to take to properly file the claim. This notice may be provided verbally, unless a written notice is requested.
- B. If a claim has been properly filed, but is lacking sufficient information about the treatment, service or procedure to be authorized, the Covered Person (or authorized representative) will be notified within 15 days. Such notice will include (a) a description of the information that is needed, (b) a request for an extension of time in which to decide the claim, and (c) notice that the information must be received within 45 days from the date the Covered Person (or authorized representative) receives the notice or the claim will be denied. Once the Claims Administrator receives the additional information, the Claims Administrator will have 15 days to decide whether to authorize the treatment, service or procedure. If the information again turns out to be insufficient, the Claims Administrator will have no choice but to deny the Pre-Service Claim.
- C. The Claims Administrator may also ask for an extension of time to decide a Pre-Service Claim for reasons other than insufficient information, but only if the reason(s) for the requested extension are beyond the control of the Claims Administrator. If a request for such extension is made, it must be made within 15 days of the receipt of

the claim. The notice will contain an explanation as to why the extension is needed and the date by which the claim will be decided. The claim will be decided within a reasonable period of time appropriate to the medical circumstances, but not more than 30 days from the date the claim was received.

Approval of a Pre-Service Claim serves only to meet the Plan's Prior Authorization requirement (see Section 2.7) so that the Covered Person will not be penalized. Prior Authorization is not a guarantee that the claim will be paid in full, as there may be other reasons to deny the claim. Once the treatment is provided, the service rendered or the procedure performed, the provider's bill will be processed as a Post-Service Claim.

- 12.4 "Time-Sensitive Claims" A Time-Sensitive Claim is a Pre-Service Claim where applying the standard timeframes for Pre-Service Claims could, in the opinion of a Physician with knowledge of the medical condition, seriously jeopardize the Covered Person's life or health or her ability to regain maximum function, or cause severe pain that cannot be adequately managed without the treatment, service or procedure that is the subject of the claim. If a Physician with knowledge of the Covered Person's medical condition determines that the claim is one for Urgent Care, and so informs the Plan, the Plan will treat the claim as one for Urgent Care. Absent a determination by the Covered Person's Physician, the Plan will determine whether a claim is one involving Urgent Care using the judgment of a prudent layperson with average knowledge of health and medicine.

In most cases, the Covered Person's health care provider will make the Time-Sensitive Claim. Such a claim and all necessary information may be submitted orally or in writing to: *SmartHealth* c/o St. John Health System-Managed Care, Attn: Time-Sensitive Claims, 28000 Dequindre, Warren, MI 48092-2468 or by facsimile (586-753-0981) or telephone (800-869-8388). The Claims Administrator will notify the Covered Person (or authorized representative) of its determination of the Time-Sensitive Claim as soon as possible, but not later than 72 hours after receiving the claim.

- A. If the Time-Sensitive Claim is improperly filed, or if insufficient information has been provided, the Covered Person (or authorized representative) will be notified within 24 hours after receiving the claim. The notice will describe the specific information necessary to complete the claim and the Covered Person (or authorized representative) will have 48 hours to provide the requested information. Once the information is received, the time-sensitive claim will be decided within 48 hours. If the Covered Person (or authorized representative) does not provide the additional information requested within 48 hours, or the information provided is still insufficient, the claim will be denied.
- B. Other than requests for additional information, there are no extensions of time for determining Time-Sensitive Claims.

- 12.5 "Post-Service Claims" A Post-Service Claim is any claim that is not a Pre-Service Claim. It is a request for the Plan to pay for medical expenses already incurred for which advance approval has already been sought or which is not required under the Plan.

SmartHealth Network providers will submit Post-Service Claims for medical services provided to Covered Persons.

If a Covered Person receives a bill directly from a provider, or pays for services directly, the Covered Person may send the claim to the Claims Administrator listed on the bill along with

any evidence of payment (e.g., a cancelled check, or a receipt or invoice marked "paid", etc.), together with the following information: the name and address of the provider, the provider's tax identification number (if known), the patient's name and address, the name, address and subscriber ID of the Plan participant, the relationship of the patient to the participant, the name and group number of the health plan, the date and place of the treatment, a description of the treatment (if not already noted on the invoice), and any other information, documents or explanatory materials that support the claim (e.g., a copy of medical records).

Post-Service Claims must be submitted in writing, either by mail to Automated Benefit Services, *SmartHealth* c/o St. John Health System, P.O. Box 37705, Oak Park, MI 48237-7705, by facsimile (586-693-4321) or by any reasonably available electronic media.

The Claims Administrator will decide Post-Service Claims within 30 days of receipt.

- A. If the Claims Administrator finds that the information provided is insufficient to determine the claim, the Covered Person (or authorized representative) will be notified within 30 days of the receipt of the claim that more information is needed. The Claims Administrator will: (a) describe the information needed, (b) explain why it is needed, (c) request an extension of time in which to decide the claim, and (d) state that the information must be received within 45 days from the date the Covered Person (or authorized representative) receives the notice or the claim will be denied.

Once the additional information is submitted, the Claims Administrator will have 15 days to decide whether and to what extent the expenses are payable as covered benefits under the Plan. If the information again turns out to be insufficient, the Claims Administrator will have no choice but to deny the Post-Service Claim.

- B. The Claims Administrator may also ask for an extension of time to decide a Post-Service Claim for reasons other than insufficient information, if the reason(s) for the requested extension are beyond the control of the Claims Administrator. If a request for such extension is made, it must be made within 30 days of the receipt of the claim and the notice must contain an explanation as to why the extension is needed and the date by which the claim will be decided. The date by which the claim must be decided cannot be more than 45 days from the date the claim was received.

- 12.6 "Concurrent Care Claims" If a Covered Person has been approved for a course of treatment under the Plan, and (a) it is determined that coverage for the course of treatment is to be reduced or terminated before the treatment is completed (whether that is measured by a pre-set time period or a pre-set number of treatments), or (b) the Covered Person wishes to extend the course of treatment beyond that which was initially authorized, the Covered Person (or authorized representative) may file a Concurrent Care Claim seeking to restore the remainder of the treatment regimen previously approved, or to request an extension of the treatment.

Concurrent Care Claims may be submitted to: *SmartHealth* c/o St. John Health System-Managed Care, Attn: Concurrent Care Claims, 28000 Dequindre, Warren, MI 48092-2468 or by facsimile (586-753-0981) or telephone (800-869-8388).

If the Concurrent Care Claim is time-sensitive, it will be decided as soon as possible but no later than 24 hours after it was received, provided that the claim was filed at least 24 hours prior to the expiration of the prescribed period of time or number of treatments originally

approved. All other Concurrent Claims will be decided quickly enough so that should the claim be denied, the Covered Person will have sufficient time to seek review of that decision before the course of treatment was initially scheduled to terminate.

12.7 “Notice of Initial Claim Denial” If the initial claim under *SmartHealth* is denied, in whole or in part, the Claims Administrator will provide to the Covered Person (or authorized representative), in writing or electronically (e.g., by e-mail), a Notice of Initial Claim Denial. An adverse benefit determination, including any denial, reduction or termination, in whole or in part, of the benefit for which the claim was filed, is a claim denial. This includes any determination based on eligibility, any application of any benefit coverage policies, or any determination that the item or service was experimental or investigational, or was not medically necessary or appropriate. This also includes a determination that the Plan will not pay the total amount of expenses Incurred, and the Covered Person must make a Copayment to satisfy the balance.

A. For Pre-Service, Concurrent Care, and Time-Sensitive Claims, the Covered person or authorized representative will be notified whether the claim is granted or denied, in whole or in part. For Post-Service Claims, the Covered Person may only be notified if the claim is denied. In all cases where the claim has been denied, in whole or in part, the Covered Person (or authorized representative) will receive a written Notice of Initial Claim Denial, except for Time-Sensitive Claims, in which case, the Covered Person (or authorized representative) may be notified first orally, and then a written or electronic notice will be sent within three days.

B. The Notice of Initial Claim Denial will include: (1) the specific reasons(s) for the denial of the initial claim; (2) the pertinent Plan provisions on which the denial is based; (3) an explanation of this Plan’s review procedures, including applicable time limits and an explanation of expedited review procedures applicable to Pre-Service or Time-Sensitive Claims; (4) a description of any additional materials necessary to complete the claim and an explanation of why such material is necessary; (5) a statement of rights to bring a civil action in court if the claim has been denied after a review of the initial denial; (6) reference to any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and that a copy of such rule, guideline or protocol may be obtained upon written request at no charge; and (7) if the adverse benefit determination is based on a matter of medical judgment, for example, it was determined that the treatment was experimental or was not medically necessary, the notice will also contain either an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of that explanation can be obtained upon written request at no charge.

12.8 “Submitting an Appeal” A Covered Person (or authorized representative) who receives a Notice of Initial Claim Denial will have up to 180 days from the date of receipt to file an appeal of that decision.

A. The appeal should include an explanation of reasons why the claim should not have been denied and any additional information, materials or documentation supporting the claim. For Time-Sensitive Claims, a request for an expedited review may be submitted orally or in writing, and all necessary information may be provided by telephone, facsimile or any other similarly expeditious method that is available. For Pre-Service, Post-Service and Concurrent Care Claims, the appeal must be in writing, and transmitted either by mail or reasonably available electronic media. For

Concurrent Care Claims, the review should be requested in time to continue the course of treatment.

- B. The person(s) reviewing the claim appeal will grant no deference to the original determination (nor to the first level review decision, if applicable), but will assess the information provided as if they were looking at the claim for the first time. Also, the person(s) reviewing the claim appeal (including any health care professionals who are consulted) will not be the same person(s) who made the initial determination (or the prior review, if any), nor will they be subordinates of those individuals. Upon written request, the Covered Person (or authorized representative) will be provided reasonable access to and copies of all documents, records and other information relevant to the claim appeal.

If the initial claim denial (or the first-level review of the claim, if applicable) is based on medical judgment (e.g., it was based on assessment that a particular treatment, drug or other item was experimental or not medically necessary), the person(s) reviewing the claim appeal will consult with a medical expert in the appropriate specialty. The identity of any medical expert consulted, whether or not her opinion is relied on in determining the claim appeal, will be retained as information relevant to the claim appeal.

12.9 “Appeal Review for Pre-Service, Concurrent Care and Time-Sensitive Claims” The Plan has one required level of review and one voluntary level of review for Pre-Service, Concurrent Care and Time-Sensitive Claims.

- A. **First-Level Appeal.** The Clinical Appeals Committee will review first-level appeals of an initial denial of a Pre-Service, Concurrent Care or Time-Sensitive Claim. The Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Appeals Committee, c/o St. John Health System-Managed Care, Appeals Coordinator, 28000 Dequindre, Warren, MI 48092-2468.

If the request is for a review of an adverse Pre-Service Claim determination, the decision on review will be made within a reasonable period of time appropriate to the medical circumstances, but not later than 30 days after the receipt of the request.

If the request is for a review of an adverse Time-Sensitive Claim determination, the decision on review will be made as soon as possible, taking into account the medical exigencies, but in any case, not later than 72 hours after the receipt of the request for review.

If the request is for review of an adverse Concurrent Care Claim determination, the timing of the decision on review will depend on the classification of the initial claim. For Pre-Service Claims, the decision will be made within 30 days after receiving the appeal. For Time-Sensitive Claims, the decision will be made within 72 hours after receiving the appeal.

- B. **Second-Level Appeal.** The Regional Advisory Committee (appointed by the Plan Administrator) will review second-level appeals. If the first-level appeal of a Pre-Service, Concurrent Care, or Time-Sensitive Claim is denied, the Covered Person (or authorized representative) may choose to submit a request for a voluntary second-level review within 60 days after receiving the denial (either in whole or in part) of the

required first-level appeal. A second-level review is not required. If a decision is made to request a second-level review, the Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Regional Advisory Committee-Appeals Coordinator, c/o St. John Health System-Managed Care, 28000 Dequindre, Warren, MI 48092-2468.

A request for a voluntary second-level review of a Pre-Service Claim, Concurrent Care, or Time-Sensitive Claim should be made in the same manner and through the same media as for filing a request for a first-level review. The second-level review decision will be made within 60 days of the receipt of the request. If a second level appeal is denied for reasons that are different from reasons given for the first level appeal, such an appeal shall be treated as though it is a first level review and not a second level review.

If the Covered Person decides not to proceed with the voluntary second-level review of a Pre-Service, Concurrent Care, or Time-Sensitive Claims, the Claims Administrator may not assert that the Covered Person failed to exhaust the administrative remedies under the Plan. If, however, the Covered Person decides to proceed with the voluntary second-level review, any applicable statute of limitations period or other similar limitation period will be tolled while the voluntary second-level review is pending. A decision to proceed (or not to proceed) with a voluntary second-level review will have no effect on the Covered Person's rights to: (1) any other benefits under the Plan, (2) information about the applicable rules, and (3) an authorized representative. The Covered Person will not be charged any fees or costs in connection with any second-level appeal request.

The Plan shall provide to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past present relationship with any party to the review process.

12.10 "Appeal Review for Post-Service Claims" This plan has two required levels of review for Post-Service Claims.

- A. First-Level Appeal. The *SmartHealth* Post-Service Appeals Committee will review first-level appeals of an initial denial of a Post-Service Claim. The Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Post-Service Appeals Committee, c/o Automated Benefit Services, P.O. Box 37705, Oak Park, MI 48237-7705 or by facsimile to: 586-693-4321. The decision on review of first-level appeals of Post-Service Claims for Medical Benefits will be made not later than 30 days after the receipt of the request.
- B. Second-Level Appeal. The Regional Advisory Committee (appointed by the Plan Administrator) will review second-level appeals. If the Covered Person receives a denial of the first-level appeal of a Post-Service Claim and is still in disagreement with

the determination, she must seek a second-level review within 60 days after receiving the denial (either in whole or in part) of the first-level appeal. The Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Regional Advisory Committee-Appeals Coordinator, c/o St. John Health System-Managed Care, 28000 Dequindre, Warren, MI 48092-2468.

The request for a second-level review of a Post-Service Claim should be made in the same manner and through the same media as for filing the request for a first-level review. The second-level review decision will be made within 30 days of the receipt of the request. If a second level appeal is denied for reasons that are different from reasons given for the first level appeal, such an appeal shall be treated as though it is a first level review and not a second level review.

12.11 “Appeal Review for Non-Covered Benefit Claims” The Plan has one required level of review and one voluntary level of review for all Non-Covered Benefit Claims which are claims for procedures, treatments or services that are not listed under the *SmartHealth* schedule of benefits, covered medical expenses or are listed as medical exclusions.

A. First-Level Appeal. The Post-Service Appeals Committee will review first-level appeals. The Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Post-Service Appeals Committee, c/o St. John Health System-Managed Care, 28000 Dequindre, Warren, MI 48092-2468.

The decision on review of a Non-Covered Benefit Claim will be made not later than 30 days after the receipt of the appeal.

B. Second-Level Appeal. The Regional Advisory Committee (appointed by the Plan Administrator) will review second-level appeals. If the first level appeal of a Non-Covered Benefit Claim is denied, the Covered Person (or authorized representative) may choose to submit a request for a voluntary second-level review within 60 days after receiving the denial (either in whole or in part) of the required first-level appeal. A second-level review is not required. If the decision is made to request a second-level review, the Covered Person (or authorized representative) should timely send all the information that supports the appeal to: *SmartHealth* Regional Advisory Committee-Appeals Coordinator, c/o St. John Health System-Managed Care, 28000 Dequindre, Warren, MI 48092-2468.

A request for a voluntary second-level review of a Non-Covered Benefit Claim should be made in the same manner and through the same media as for filing a request for a first-level review. The second-level review decision will be made within 60 days of the receipt of the appeal.

If the Covered Person decides not to proceed with the voluntary second-level review of a Non-Covered Benefit Claim, the Claims Administrator may not assert that the Covered Person failed to exhaust the administrative remedies under the Plan. If, however, the Covered Person (or authorized representative) decides to proceed with the voluntary second-level review, any applicable statute of limitations period or other similar limitation period will be tolled while the voluntary second-level review is pending. A decision to proceed (or not to proceed) with a voluntary second-level review will have no effect on the Covered Person’s right to: (1) any other benefits

under the Plan, (2) information about the applicable rules, and (3) an authorized representative. The Covered Person will not be charged any fees or costs in connection with any second-level appeal request.

The Plan shall provide to any claimant, upon request, sufficient information relating to the voluntary level of appeal to enable the claimant to make an informed judgment about whether to submit a benefit dispute to the voluntary level of appeal, including a statement that the decision of a claimant as to whether or not to submit a benefit dispute to the voluntary level of appeal will have no effect on the claimant's rights to any other benefits under the Plan and information about the applicable rules, the claimant's right to representation, the process for selecting the decisionmaker, and the circumstances, if any, that may affect the impartiality of the decisionmaker, such as any financial or personal interests in the result or any past or any past present relationship with any party in the review process.

12.12 "Notification of Decisions on Appeal Reviews" If the denial of a claim is appealed, the Covered Person (or authorized representative) will be notified in writing or electronically (e.g., by e-mail) of each decision on review, whether favorable or adverse, within the time frames noted above, except for Time-Sensitive Claims, in which case, the Covered Person (or authorized representative) may be notified first orally, and then a written or electronic notice will be sent within three days.

- A. If the appeal is denied, in whole or in part, whether at the first or second level, the notice of the denial on appeal will include: (1) the specific reasons(s) for the denial; (2) the pertinent Plan provision(s) on which the denial is based; (3) an explanation of the scientific or clinical judgment on which the determination was based, or a statement that a copy of that explanation can be obtained upon written request at no charge, where the initial adverse determination is based on medical judgment that treatment was experimental or was not medically necessary; (4) a statement of entitlement to receive, upon written request and at no cost, reasonable access to and copies of the documents, records and other information relevant to the decision to deny the claim, in whole or in part; (5) reference to any rule, guideline, protocol, or similar document or criteria relied on in making the initial determination, and a statement that a copy of such rule, guideline or protocol may be obtained upon written request at no charge; (6) following the first-level review, an explanation of the Plan's second-level review procedures, including applicable time limits, and, if applicable, an explanation of expedited review procedures for Time-Sensitive or Pre-Service Claims; (7) an explanation of voluntary levels of review which the Plan makes available, if any, including applicable time limits for electing such voluntary review procedures; and (8) if the claim is denied on the required first level of review for Pre-Service and Time-Sensitive Claims or on the required second level of review for Post-Service Claims, a statement that the Covered Person may seek to have the claim paid by bringing a civil action in court.
- B. For Pre-Service, Concurrent Care, Time-Sensitive, Post-Service and Non-Covered Benefit Claims, the decision of the Claims Administrator, or its delegate, on the required level(s) of review is final. The Covered Person may, however, elect to proceed to a voluntary level of review for Pre-Service, Concurrent, and Time-Sensitive Claims.

C. If the claim is denied, in whole or in part, after all stages of these procedures have been completed (except any voluntary levels of review), the Covered Person has the right to seek to have the claim paid by filing a civil action in court, but she will not be able to do so unless she has completed all of the appropriate levels of review (except any voluntary levels) required under the Plan. If she does not follow and complete these procedures, a review of the claim in court will be subject to dismissal for failure to exhaust the claim and review rights under this Plan. If the Covered Person wishes to file a claim in court, she must do so within one year of the date on which she receives notice of the final denial of the claim (or, the date on which she receives notice of the denial on second-level review). If, however, the Claims Administrator fails to comply with any of the deadlines described above or fails to adequately inform the Covered Person of her procedural rights, she may treat these procedures as having been completed, and file a claim in court. The Covered Person must file a claim in court within one year of the date she knew, or should have known, of the Claims Administrator's material failure to comply with these procedures.

12.13 "Other Benefit Determinations" If a Covered Person makes a claim for a benefit including but not limited to a determination of eligibility under Section 6.1 or Article 8, which claim is not a Pre-Service Claim, a Post-Service Claim, a Concurrent Care Claim or a Time-Sensitive Claim as defined in this Article 12, such claim shall be handled in accordance with the provisions of Section 12.5 as a Post-Service Claim, and, to the extent a second review is necessary, the Regional Advisory Committee will review second-level appeals.

12.14 "Authority of Claims and Appeals Administrators" The Claims Administrator, the Clinical Appeals Committee and the Post Service Appeals Committee shall be appointed by the Plan Administrator and are hereby granted the discretionary authority and power to make factual findings, to fix omissions, to resolve Plan ambiguities, to construe the terms of the Plan and to make benefit eligibility determinations with respect to the benefit option for which that claims fiduciary is appointed. Such fiduciaries as are individuals shall serve until their resignation, death or removal with or without cause by the board of trustees. Each committee shall continue until the Plan is amended to eliminate that committee. The committees shall rely on the information provided by the Plan and Covered Persons in deciding appeals and shall abide by the rules established by the Plan Administrator. No health care professional who consents on or makes a decision as to any appeal may be an individual who was consulted in connection with the original benefit claim nor the subordinate of any such individual.

ARTICLE 13—FIDUCIARY RESPONSIBILITIES

13.1 "Duties and Obligations of Fiduciaries" All actions by "fiduciaries" (as that term is defined in Section 3(21) (A) of ERISA) shall be in accordance with the terms of this Plan insofar as such documents are consistent with the provisions of Title I of ERISA. Each fiduciary shall act solely in the interest of Covered Persons and for the exclusive purpose of providing benefits and defraying reasonable administrative expenses. Each fiduciary shall discharge her or its respective duties hereunder with the care, skill, prudence and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims.

13.2 “Allocation of Fiduciary Responsibilities”

- A. The Plan Administrator shall be the named fiduciary for the following purposes:
 - 1. For the control and management of the operation and administration of the Plan, except for those duties herein specifically allocated to the appeals committees and the board of trustees.
 - 2. For the furnishing to the other fiduciaries hereunder such information related to the administration of the Plan as they may require.
 - 3. For selecting and monitoring the Claims Administrator and certain appeals committee members per Section 1.7.
 - 4. For determining if an expense is Reasonably Necessary under Section 1.58.
 - 5. For determining if a cost or service violates the Ethical and Religious Directives for Catholic Health Care Services under Section 3.1.37.
 - 6. For determining whether a Covered Person's benefits may be terminated for just cause in accordance with Section 6.9.

- B. The board of trustees of the Plan Administrator shall be the named fiduciary for the following purposes:
 - 1. For the amendment of the Plan, as provided in Section 14.5.
 - 2. For the removal of fiduciaries and the appointment of a successor if the Plan Administrator cannot or does not appoint a successor.
 - 3. For the appointment and removal of the claims and appeals fiduciaries as provided in Section 12.14.
 - 4. For the designation of any employer to become a Participating Employer, as provided in Section 14.15.
 - 5. For the termination of the Plan, as provided in Section 14.5 and 14.16.
 - 6. For determining matters of fiduciary indemnification under Section 14.2.

- C. Each board of trustees shall be the named fiduciary for the purpose of terminating the participation of its Participating Employer in the Plan, as provided in Section 14.5 and 14.16.

- D. The appeals committees shall be the named fiduciaries for the purpose of hearing first level appeals under Article 12. The Regional Advisory Committee shall be the named fiduciary for purposes of hearing second level appeals pursuant to Article 12.

- E. Each fiduciary shall be responsible only for the specific duties assigned herein and shall not be directly or indirectly responsible for the duties assigned to another fiduciary.

ARTICLE 14—OTHER

14.1 "Plan Administrator" The administration of the Plan shall be conducted under the supervision of the Plan Administrator. The board of trustees hereby gives the Plan Administrator the discretionary authority and power to make factual findings, to fix omissions, to resolve Plan ambiguities, to construe the terms of the Plan, and to make benefit eligibility determinations. It shall be a principal duty of the Plan Administrator to see that the administration of the Plan is carried out in accordance with its terms, for the exclusive purposes of providing benefits to the Participants and their Beneficiaries in accordance with the documents and instruments governing the Plan. For this purpose, the Plan Administrator's powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

- A. To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan, including the establishment of any claims procedures that may be required by applicable provisions of law;
- B. To interpret and construe the terms of the Plan, its interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plan;
- C. To decide all questions concerning the Plan, and to determine the eligibility of any person to participate in or receive benefits under the Plan, except as provided in Article 12;
- D. To compute the amount of benefits which will be payable to any Participant or other person, organization or entity, to determine the proper recipient of any benefits payable hereunder and to authorize the payment of benefits, all in accordance with the provisions of the Plan and the applicable requirements of law.
- E. To appoint such agents, counsel, accountants, consultants and actuaries as may be required to assist in administering the Plan and supporting the claims fiduciaries;
- F. To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such action to be by written instrument and in accordance with ERISA Section 405; and
- G. To delegate its authority to administer claims for benefits under the Plan by written contract with a third party administrator.

14.2 "Indemnification of Fiduciaries"

- A. The Plan Administrator shall indemnify each current or former director, officer or employee of the Plan Administrator who is, or is threatened to be made, a party to any threatened or pending action or proceeding, whether civil, criminal, administrative or investigative, including actions by or in the right of the Plan Administrator, by reason

of the fact that such director, officer or employee is or was serving at the request of the Plan Administrator as a "fiduciary" (as defined by Section 3(21) (A) of ERISA) with regard to the Plan, against expenses (including attorneys' fees), claims, fines, judgments, taxes, causes of action or liability and amounts paid in settlement, actually and reasonably incurred by her in connection with such action or proceeding, unless such expense, claim, fine, judgment, taxes, cause of action, liability or amount arose from her gross negligence, fraud or willful breach of her fiduciary responsibilities under ERISA, except, that with respect to an action by or in the right of the Plan Administrator, indemnification shall be made only against expenses (including attorneys' fees).

- B. The Plan Administrator shall advance all expenses (including attorneys' fees) incurred by any director, officer, or employee described in Section 14.2.A in defending a civil, criminal, administrative or investigative action, suit or proceeding pending the final disposition of such action, suit or proceeding unless the board of trustees, by a majority vote of a quorum consisting of directors who were not or are not parties to the action, suit or proceeding concerned determine that under the circumstances of the individual case the person by her conduct is not entitled to indemnification under Section 14.2.A because of her gross negligence, fraud or willful breach of her fiduciary responsibilities, upon receipt of an undertaking, with such security as the board of trustees may reasonably require, by or on behalf of the director, officer or employee to repay such amounts unless it shall ultimately be determined that she is entitled to be indemnified by the Plan Administrator as authorized by this Section 14.2.
- C. To the extent that any current or former director, officer, or employee has been successful on the merits or otherwise in the defense of the action, suit or proceeding, or in defense of any claim, issue or matter therein, referred to in Section 14.2.A she shall be indemnified against expenses (including attorneys' fees) actually and reasonably incurred by her in connection therewith and if she was advanced expenses as provided in Section 14.2.A, her undertaking shall be canceled by the Plan Administrator. If any action, suit or proceeding shall terminate by judgment or order adverse to the director, officer or employee, or settlement, conviction or upon a plea of nolo contendere or its equivalent, the board of trustees, in the same manner provided in Section 14.2.A with reference to advancement of expenses, shall (unless ordered by a court to make indemnification) make a determination whether indemnification of the director, officer or employee is not proper in the circumstances because she has been guilty of gross negligence, fraud or willful breach of her fiduciary responsibilities and, if it is determined that the person is so entitled to indemnification, then she shall be indemnified against expenses (including attorneys' fees) claims, fines, judgments, taxes, causes of actions or liability and amounts paid in settlement, actually and reasonably incurred by her in connection with such action or proceeding and, if she was advanced expenses as provided in Section 14.2.A, her undertaking shall be canceled. The termination of any action or proceeding by adverse judgment or order, conviction settlement or plea of nolo contendere or the equivalent, shall not, of itself, create a presumption that the director, officer, or employee was guilty of gross negligence, fraud or willful breach of her fiduciary responsibilities.
- D. The indemnification provided by this Section 14.2 shall not be deemed exclusive of any other rights to which any director, officer, or employee may be entitled, and shall

continue as to a person who has ceased to be a director, officer, or employee and shall inure to the benefit of the personal representative, heirs and legatees of such a person.

- E. If a director, officer, member or employee of the Plan Administrator is entitled to indemnification by more than one Participating Employer with respect to any one action, suit or proceeding, such person shall be entitled to be indemnified only once and the Participating Employers shall, in their sole discretion, decide how to allocate such indemnification among them.

14.3 “Errors” An error cannot give a benefit to a person if she is not actually entitled to the benefit. If the person is not eligible for a benefit, but has made a Required Contribution to receive that benefit, she will be reimbursed any amounts improperly paid, but in no event will such payments entitle the person to benefits for which she is otherwise ineligible.

14.4 “Overpayments” An overpayment occurs if the Plan pays an amount not payable under the Plan, if the Plan pays an expense or benefit more than once, or if an expense or benefit is paid by both the Plan and a third party. An expense or benefit is considered paid if it is paid to the Covered Person or to someone else (e.g., a health care provider) on behalf of a Covered Person.

If an Overpayment is made by the Plan, the Plan has the right to recover the Overpayment. If that Overpayment is made to a health care provider, the Plan may request a refund of the Overpayment from either the Covered Person or the provider. If the refund is not received from either the Covered Person or the provider, the Overpayment may be deducted from future Plan benefits available to the Covered Person or Eligible Dependents or from the Covered Person’s wages, but the amounts withheld may not reduce her pay below the applicable state minimum wage law to the extent permitted by law.

Any Overpayment the Covered Person owes due to her or her dependent’s ineligibility for Plan benefits will be offset by the amount of any contributions she paid for coverage for the person while ineligible.

14.5 “Amendment, Modification, or Termination of the Plan” The Plan Sponsor may by action of its Board of Trustees or its delegate amend, modify, or terminate this *SmartHealth* Plan at any time, for any reason, with respect to any individual, including but not limited to employees, Eligible Dependents, retirees and disabled individuals, in its sole discretion. Any Amendment adopted will be in writing and executed by the individual so authorized by the Plan Sponsor, as the case may be. Any amendment may be made retroactively effective to the extent not prohibited by ERISA and the Code. Coverage upon termination will be governed by the terms of the Plan. Any affiliate of the Employer which participates in the Plan cannot amend or terminate the Plan.

14.6 “Entire Representation” This document, and the appropriate accompanying handbooks, insurance contracts and certificates, together are the entire description of the benefits provided by this Plan and they supersede any previous or contemporary document, representation, or agreement (whether written or oral). This document may be amended or supplemented (and any future document may be entered into) only in writing signed by the Plan Sponsor.

- 14.7 “Acceptance, Cooperation” All persons accepting benefits under this Plan are considered to have accepted its terms. All parties to this Plan and all persons claiming any interest in or benefits from the Plan agree to perform any act and to execute any documents which may be necessary or desirable to carry out this Plan or any of its provisions.
- 14.8 “Governing Law” The Plan will be construed and enforced in accordance with the laws of the State of Michigan to the extent not preempted by federal law.
- 14.9 “Non-Assignability of Rights” No interest under the Plan is subject to assignment or alienation, whether voluntary or involuntary. Any attempt to assign or alienate any interest will be void.
- 14.10 “Severability” The enforceability of any provision of the Plan will not affect the enforceability of the remaining provisions of the Plan.
- 14.11 “Requirements for Minimum Hospital Stay Following Birth of a Child” Notwithstanding anything in this Plan to the contrary, the Plan shall not:
- A. restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child following a vaginal delivery to less than 48 hours or, following a cesarean section, to less than 96 hours; or
 - B. require that a provider obtain authorization from the Plan or any other party before prescribing a length of Hospital stay less than that required under (a) above. The Plan shall not deny any Employee or Dependent eligibility or continued eligibility under the Plan, to enroll or renew coverage solely for the purpose of avoiding the requirements above. The Plan shall not provide any monetary payments or rebates to Employees or Dependents to encourage mothers to accept less than the minimum protections available under this section. The Plan shall not penalize or otherwise reduce or limit the reimbursement of an attending provider because such provider provides care to an individual, Employee or Dependent in compliance with the requirements of this section of the Plan, nor shall such provider receive any incentive from the Plan to induce them to provide care to an individual or Employee in a manner inconsistent with this section. The Plan shall not restrict benefits for any portion of a period within a Hospital length of stay required under this in a manner which is less favorable than the benefits provided for any preceding portion of such stay.
- 14.12 “Requirements for Certain Reconstruction Procedures” If a Covered Person or spouse is receiving benefits in connection with a mastectomy and elects breast reconstruction in connection with a mastectomy, *Smart Health* will also cover:
- reconstruction of the breast on which the mastectomy was performed;
 - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
 - prostheses and physical complications of all stages of mastectomy, including lymphedemas.

This must be provided in a manner determined in consultation with the attending Physician and patient. This coverage may be subject to annual Deductibles and Co-insurance provisions as is deemed appropriate and as is consistent with the Copayments and annual

Deductibles and Co-insurance for other benefits under the plan or coverage. This coverage is required by Federal law.

In addition, the Plan (1) will not deny eligibility or continue eligibility to enroll or renew coverage under the terms of the Plan, solely for the purpose of avoiding this coverage, or (2) penalize or otherwise reduce or limit the reimbursement of an attending provider, or provide incentives (monetary or otherwise) to an attending provider, to induce the provider to provide care in a manner inconsistent with the coverage required under the Women's Health and Cancer Rights of 1998.

14.13 "Qualified Medical Child Support Orders"

- A. Upon receipt by the Plan Administrator of a medical child support order, the Plan Administrator shall notify the Participant and the potential alternative recipient of the child support order that they have received the medical child support order within 15 days of the Plan Administrator's receipt of the medical child support order. The notification shall describe the procedures for determining whether the child support order is a Qualified Medical Child Support Order as defined in Section 609 of the ERISA. The procedures shall permit a potential alternative recipient to designate a representative to receive copies of notices with respect to a medical child support order. The Plan Administrator shall determine if the medical child support order is a Qualified Medical Child Support Order within 60 days of receipt of such order, unless circumstances cause a delay. If a delay is required, the potential alternate recipient shall be notified of any such delay in writing.
- B. The Plan Administrator shall review the medical child support order or request legal counsel to review the medical child support order and verify that the following items are appropriately addressed in the medical child support order:
 - 1. the medical child support order must create or recognize the existence of an alternate recipient's right to receive benefits for which the Participant or beneficiary is eligible under the Plan or to assign those rights;
 - 2. the medical child support order must identify the Plan to which it applies and the parties that will be responsible for paying for the benefits that are the subject of the order;
 - 3. the medical child support order must clearly specify the name and last known mailing address of each alternate recipient covered by the order;
 - 4. the medical child support order must specify in a reasonable description the type of coverage to be provided by the Plan to each alternate recipient or the manner in which the type of coverage is to be determined;
 - 5. the medical child support order must specify that the order applies to this Plan and the period to which the order applies;
 - 6. the medical child support order must not require the Plan to provide any type or form of benefit not otherwise provided under the Plan; and
 - 7. the medical child support order must be issued by a court of competent jurisdiction or, for orders entered on or after January 1, 1997, any decree or

order of an administrative agency of a state government which has authority to issue such judgments, decrees or orders, and it must clearly be an order, judgment, decree or approval of a settlement.

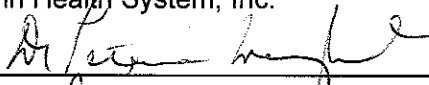
- C. If the Plan Administrator determines the medical child support order satisfies all of the above requirements, then the Plan Administrator shall notify, in writing, each alternate recipient and the Participant or beneficiary related to such alternate recipient that the order is a Qualified Medical Child Support Order. The Plan Administrator shall also notify the Participant that they must execute a new salary redirection election to cover the cost of such coverage or otherwise notify the party responsible for paying for the coverage of their obligations with respect to payment for the coverage. If the Plan Administrator determines that the order is not a Qualified Medical Child Support Order, then the Plan Administrator shall notify, in writing, each proposed alternate recipient and the related Participant or beneficiary that the order is not a Qualified Medical Child Support Order and why the order failed to qualify as such and of their right to appeal such decision.
 - D. Notwithstanding the preceding to contrary, a "National Medical Support Notice" received by Plan Administrator shall be deemed to be a Qualified Medical Child Support Order to the extent required and the Child Support Performance and Incentive Act of 1998.
 - E. The Plan Administrator shall treat each alternate recipient under a Qualified Medical Child Support Order as a Participant under the Plan for all reporting and disclosure requirements imposed by the Employee Retirement Income Security Act.
 - F. The cost of the coverage provided under the qualified medical child support order shall be paid by the party designated as responsible for paying for such coverage in the order. If the medical child support order does not specify the party responsible for payment for the alternate recipient's coverage under the medical child support order, then the Plan shall deduct the cost of coverage from the Participant's compensation. The Plan Administrator shall not consider the alternate recipient's eligibility for Medicaid when enrolling the alternate recipient in the Plan. The Plan shall comply with the alternate recipient's assignment rights under Medicaid, if any.
- 14.14 "Requirements for College Students with a Serious Medical Condition" If any Eligible Dependent attending college or other post secondary educational institution on a full time basis as determined by the institution is diagnosed with a serious medical condition which prevents them from attending school full time, the Plan will allow the Eligible Dependent continued access to the Plan for one year following the first day of a medically necessary leave of absence or the date on which the coverage would otherwise have ended. To take advantage of this continuation coverage benefit, the Eligible Dependent must provide written certification from a Physician.
- 14.15 "Adoption by Participating Employers"
- A. Any wholly-owned affiliated entity may adopt this Plan and all provisions thereof, with the consent of the board of trustees of the Plan Administrator, but only if such adopting entity's board of trustees or other managing body resolves to adopt the Plan and the adopting entity signs a Joinder Agreement provided by the Plan

Administrator. Any such adopting employer shall be known as a "Participating Employer".

- B. The Plan Administrator shall have authority to make any and all necessary rules or regulations, binding upon all Participating Employers and all Covered Persons, to effect the purpose of Section 14.15 and Section 14.16. The Plan Administrator shall determine the form and procedures applicable to Joinder Agreements. Such Joinder Agreements shall set out the intent of each Participating Employer to participate in Plan and to be bound by the Plan's terms. Joinder agreements shall also describe the employees and dependents who shall be eligible to participate in the Plan as Covered Persons.
 - C. Each Participating Employer shall be deemed to be a part of this Plan; provided, however, that with respect to all of its relations with the Plan Administrator for the purpose of this Plan, each Participating Employer shall be deemed to have designated irrevocably the Plan Administrator as its agent. Unless the context of the Plan clearly indicates the contrary, the word "employer" shall be deemed to include each Participating Employer as related to its adoption of the Plan.
 - D. An Associate may be transferred between Participating Employers, and in the event of any such transfer, the Associate involved shall carry with her accumulated service and eligibility. No such transfer shall effect a termination of employment hereunder, and the Participating Employer to which the Associate is transferred shall thereupon become obligated hereunder with respect to such Associate in the same manner as was the Participating Employer from whom the Associate was transferred.
- 14.16 "Discontinuance of Participation" Any Participating Employer shall be permitted to discontinue or revoke its participation in the Plan by delivering to the Plan Administrator a resolution of its board of trustees or other managing body evidencing such intent. Any such discontinuance or revocation may only be made as of the first day of the next Plan Year without the prior approval of the board of trustees of the Plan Administrator. At the time of any such discontinuance or revocation, satisfactory evidence thereof shall be delivered to the Plan Administrator. The Plan Administrator shall thereafter transfer, deliver and assign contracts and other assets allocable to the Participants of such Participating Employer to such new administrator as shall have been designated by such Participating Employer, if it has established a separate medical care plan for its Associates. If no successor is designated, the Administrator shall retain such assets for the Associates of said Participating Employer.
- 14.17 "Provider Rate Appeals" If a service provider believes that reimbursement received from the plan is not correct, the service provider may appeal the payment in accordance with its contract. The Provider Rate Appeals Committee shall review first level rate appeals from service providers who claim that errors have been made at the first level as to the applicable rate being paid. There shall be no second level appeals of provider rates.
- 14.18 "Construction of Terms" Words of gender shall include persons and entities of any gender, the plural shall include the singular, and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

IN WITNESS WHEREOF, St. John Health System, Inc. has caused this Plan to be executed in its name and on its behalf and that of the other Michigan Health Ministries of Ascension Health as of the Plan Effective Date, this first day of January, 2010, by its duly authorized officer.

St. John Health System, Inc.

By 

Title President and CEO

ADDENDUM 1 – Health Ministry Information – St. John Health System

Health Ministry	St. John Health System
City, State	Warren, MI

Eligibility Requirements (see Section 5.1 for details)

You are eligible to participate in the Plan if you complete the Waiting Period, and you are an employee of the Health Ministry as described in one of the following groups. This Plan will pay the Medicare Deductible and co-insurance for those members in Group C, E, and F who are Medicare eligible. If the service is not an eligible expense under Medicare, the service is not an eligible expense under this Plan.

Group	Description
A	Those SJHS employees in a 70 Hour position (an employee in that position is authorized to work at least 70 hours each pay period).
B	Those SJHS employees in a 40/69 Hour position (an employee in that position is authorized to work 40 to 69 hours each pay period).
C	Employees of Blaine Hospital who retired before March 31, 1987.
D	Those Company employees working on a fee per service basis or working under the FlexChoice Program.
E	Those employees of Providence who were age 55 or older and who had at least 10 years of “Pension Service” (each calendar year of employment in which you have 1,000 hours of service) with Providence before July 1, 1991, and who retired before July 1, 1991.
F	Those employees of Providence who were hired before June 1, 1990, who were actively employed by Providence (including leaves of absences) on June 30, 1991, and who satisfy the 85 Coverage Rule or the 80 Coverage Rule. The “85 Coverage Rule” is satisfied if your age and service equal 85 or more and you are at least age 55 when you retire. The “80 Coverage Rule” is satisfied if your age and service equal 80 to 84 and you are at least age 55 when you retire.
G	Non-union staff employees of Senior Services classified as full-time.
H	Management employees of Senior Services classified as full-time.
I	Administrator employees of Senior Services classified as full-time.
J	Union employees of Father Murray Nursing Center classified as full-time.

The Group to which you belong will determine your Waiting Period, if any. The Waiting Period is as follows for each Group:

A, B, D	The Waiting Period ends on the first day of the month coincident with or next following your date of hire or transfer to an employee group covered by the Plan.
G, H, I, J	The Waiting Period ends on the first day of the month coincident with or next following 3 consecutive months of service.

Spousal Surcharge:

A, B, G, H, I	<p>If the Eligible Employee’s Spouse is employed and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>Spousal surcharge will not be applicable if the spouse has Medicare or an employer provided retirement medical plan.</p> <p>If it is determined that the spouse did not comply with the spousal surcharge provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>
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ADDENDUM 1 – Health Ministry Information – St. John Health System

Health Ministry

St. John Health System – MRG

City, State

Warren, MI

Eligibility Requirements (see Section 5.1 for details)

You are eligible to participate in the Plan if you complete the Waiting Period, and you are an employee of the Health Ministry as described in one of the following groups:

Group	Description
A	Those MRG employees in a 80 Hour position (an employee in that position is authorized to work at least 80 hours each pay period).
B	Those MRG employees in a 40/79 Hour position (an employee in that position is authorized to work 40 to 79 hours each pay period).
C	Those MRG employees who are classified as Physicians.

The Group to which you belong will determine your Waiting Period, if any. The Waiting Period is as follows for each Group:

A, B, C	The Waiting Period ends on the first day of the month coincident with or next following your date of hire or transfer to an employee group covered by the Plan.
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Spousal Surcharge:

A, Level I & II Associates	<p>If the Eligible Employee's Spouse is employed and medical coverage is provided under a plan offered by the Spouse's employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse's plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>Spousal surcharge will not be applicable if the spouse has Medicare or an employer provided retirement medical plan.</p> <p>If it is determined that the spouse did not comply with the spousal surcharge provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>
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ADDENDUM 1 – Health Ministry Information – Genesys Health System

Health Ministry	Genesys Health System and wholly-owned subsidiaries
City, State	Grand Blanc, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class:	Full Time and Part Time Hourly Non Union and Salaried Professional employees of Genesys Regional Medical Center scheduled to work at least 32 hours bi-weekly
Service Requirement:	None
Coverage Begins:	1 st of month following Date of Hire

ADDENDUM 1 – Health Ministry Information – Genesys Health System

Health Ministry	Genesys Health System and wholly-owned subsidiaries
City, State	Grand Blanc, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class:	<ul style="list-style-type: none"> • Full Time and Part Time Supervisors, Managers, Directors, Executives and Physicians of Genesys Regional Medical Center scheduled to work a minimum of 32 hours bi-weekly • Full Time Interns and Residents of Genesys Regional Medical Center
Service Requirement:	None
Coverage Begins:	Date of Hire

ADDENDUM 1, SCHEDULE A – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	Borgess Medical Center, including Borgess Pipp Hospital (Non-Union)
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> ○ <u>Full-Time Employees</u> All active full-time employees with assigned hours of 36 or more per week who have completed the waiting period. ○ <u>Regular Part-Time Employees</u> All active regular part-time employees with assigned hours of at least 20 but less than 36 per week who have completed the waiting period.
Service Requirement (Waiting Period):	Three months of continuous employment
Coverage Begins:	1 st of month following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan. However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1, SCHEDULE B – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	Textile Systems, Inc. (Non-Union)
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> ○ <u>Full-Time Employees</u> All active full-time employees with assigned hours of 36 or more per week who have completed the waiting period. ○ <u>Regular Part-Time Employees</u> All active regular part-time employees with assigned hours of at least 20 but less than 36 per week who have completed the waiting period.
Service Requirement (Waiting Period):	Three months of continuous employment
Coverage Begins:	1 st of month following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan. However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1, SCHEDULE C – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	ProMed Healthcare, Inc.
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> ○ <u>Full-Time Employees</u> All active full-time employees with assigned hours of 36 or more per week who have completed the waiting period. ○ <u>Regular Part-Time Employees</u> All active regular part-time employees with assigned hours of at least 20 but less than 36 per week who have completed the waiting period.
Service Requirement (Waiting Period):	Three months of continuous employment
Coverage Begins:	1 st of month following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan. However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1, SCHEDULE D – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	Borgess Ambulatory Care Corporation
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> o <u>Full-Time Employees:</u> All active full-time employees working at least 36 hours per week who have completed the waiting period. o <u>Regular Part-Time Employees:</u> All active regular part-time employees working at least 20 but less than 36 hours per week who have completed the waiting period.
Service Requirement (Waiting Period):	Three months of continuous employment
Coverage Begins:	1 st of month following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan. However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1, SCHEDULE E – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	Borgess Visiting Nurse & Hospice Services and Borgess Visiting Nurses Home Care
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> ○ <u>Full-Time Employees:</u> All active full-time employees working at least 36 hours per week who have completed the waiting period. For this purpose, the waiting period is 30 days of full-time service for Employer. ○ <u>Regular Part-Time Employees:</u> All active full-time employees working at least 30 hours but less than 36 hours per week who have completed the waiting period. For this purpose, the waiting period is 30 days of full-time service for Employer. ○ <u>Part-Time Employees:</u> All active part-time employees working at least 20 but less than 30 hours per week who have completed the waiting period. For this purpose, the waiting period is 30 days of part-time service for Employer.
Service Requirement (Waiting Period):	30 days of continuous employment
Coverage Begins:	Following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1, SCHEDULE F – Health Ministry Information – Borgess Health Alliance, Inc.

Health Ministry	Borgess Lee Memorial Hospital
City, State	Kalamazoo, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Class of Employee:	<ul style="list-style-type: none"> ○ <u>Full-Time Employees</u> All active full-time employees with assigned hours of 36 or more per week who have completed the waiting period. ○ <u>Regular Part-Time Employees</u> All active regular part-time employees with assigned hours of at least 20 but less than 36 per week who have completed the waiting period.
Service Requirement (Waiting Period):	30 days of continuous employment
Coverage Begins:	1 st of month following completion of Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed, benefit eligible, and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan. However, if the premium contribution for the spouse’s coverage is \$90 or more per month they could choose to be covered solely under the associate’s Borgess plan.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1 – Health Ministry Information – St. Mary’s of Michigan

Health Ministry	St. Mary’s of Michigan (SMOM)
City, State	Saginaw, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 of the Plan).

Eligible Class	<ul style="list-style-type: none"> • a full-time associate regularly scheduled to work at least 60 hours biweekly; or • a part-time associate regularly scheduled to work at least 30 hours biweekly or on a “Weekends Only” basis; or • a retired associate of the employer upon having attained age fifty-five (55) with a minimum of five (5) years of service and was covered on the Plan on the date of his/her retirement; or • a Physician as specified in their employment contract with St. Mary’s of Michigan or if such contract is silent on eligibility then eligibility provisions of this plan shall prevail; or • an associate who was receiving benefits under the Ascension Health long-term disability plan, formerly known as the Daughters of Charity National health System Long Term Disability Plan (“Ascension Health LTD Plan”) as of July 1, 2004 and who first became eligible for benefits and began receiving benefits under the Ascension Health LTD Plan before July 1, 2002; provided that in order to remain eligible to participate in the SmartHealth Plan, such individuals must continue to be eligible for benefits and continue to receive benefits under the Ascension Health LTD Plan.
Service Requirement	<p>30 days of continuous employment in an Eligible Class, except for:</p> <ul style="list-style-type: none"> • Any employee who transferred from an Ascension facility and became an eligible Associate of St. Mary’s of Michigan will not be required to satisfy any waiting period provided that the Associate had previously met the waiting period during their employment with Ascension. • Any Physician whose employment contract waives the waiting period or otherwise provides a shorter waiting period.
Coverage Begins	The first day following the Service Requirement.
Spousal Access	<p>If the Eligible Employee’s Spouse is employed full-time and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>Spousal Access will not be applicable if: the Spouse is disabled, the Spouse is retired, the Spouse is self-employed or employed less than full-time, or the Spouse has to pay 100% of the premium for his/her own coverage.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1 – Health Ministry Information – St. Mary’s of Michigan Standish Hospital

Health Ministry	St. Mary’s of Michigan Standish Hospital (SMMSH)
City, State	Standish, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 for details)

Eligible Employee:	<ul style="list-style-type: none"> ▪ Full-Time associates scheduled to work at least 72 hours bi-weekly are eligible for Employee coverage and Dependent coverage ▪ Part-Time associates scheduled to work at least 32 hours bi-weekly are eligible for Employee Coverage only; may purchase voluntary coverage ▪ Short-hour or Occasional associates are not eligible for health benefits
Service Requirement:	<ul style="list-style-type: none"> ▪ Full-Time Managers, Directors Coordinators and Critical Classifications: None ▪ Full-Time Other: 90 days of continuous employment in an Eligible Class ▪ Part-Time: One year of continuous employment <p>Any employee who transferred from an Ascension facility and became an eligible Associate of SMMSH will not be required to satisfy any waiting period provided that the Associate had previously met the waiting period during their employment with Ascension.</p>
Coverage Begins:	First of month following completion of Service Requirement or date of hire for positions without a service requirement
Spousal Access:	<p>If the Eligible Employee’s Spouse is employed full-time and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>Spousal Access will not be applicable if: the Spouse is disabled, the Spouse is retired, the Spouse is self-employed or employed less than full-time, or the Spouse has to pay 100% of the premium for his/her own coverage.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>

ADDENDUM 1 – Health Ministry Information – St. Joseph Health System

Health Ministry	St. Joseph Health System
City, State	Tawas City, MI
Effective Date of Addendum	January 1, 2009

Eligibility Requirements (see Section 5.1 of the Plan for details)

Eligible Employees:	Associates scheduled to work either 24 hours per week or 48 hours bi-weekly
Service Requirement:	None
Coverage Begins:	1st of month following date of hire or eligible status change
Spousal Access:	<p>If the Eligible Employee’s Spouse is employed full-time and medical coverage is provided under a plan offered by the Spouse’s employer, the Spouse must enroll for Employee coverage and must seek services in compliance with the Spouse’s plan, in order for the Spouse to be eligible for coordination of benefits under this Plan.</p> <p>Spousal Access will not be applicable if: the Spouse is disabled, the Spouse is retired, the Spouse is self-employed or employed less than full-time, or the Spouse has to pay 100% of the premium for his/her own coverage.</p> <p>If it is determined that the spouse did not comply with the spousal access provision, the coverage will be terminated retroactive to January 1st of current calendar year or coverage begin date, whichever is later.</p>