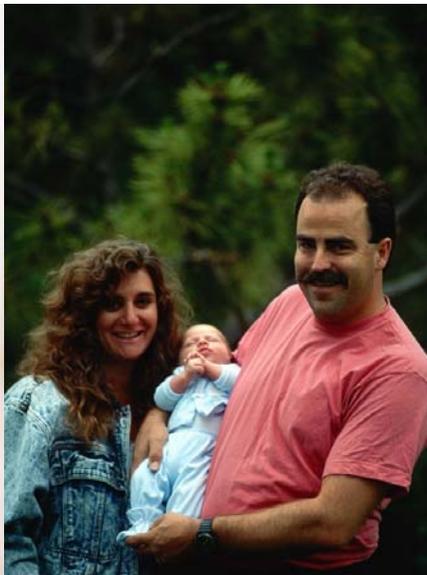


JANUARY 1, 2010

PORT HURON HOSPITAL

YOUR MEDICAL PLAN & O U



NGS
CORESOURCE
A Trustmark Company
PERSONAL. FLEXIBLE. TRUSTED.

Dear Participant,

Welcome to the health plan provided to you and your eligible family members by Port Huron Hospital! Please take some time to review this booklet to help you maximize your benefit program. Then keep it handy where you can refer to it whenever needed.

This booklet includes the following sections:

Overview Of Benefits: This section of the plan provides a brief, easy-to-read outline of benefits for your reference. It also describes the important criteria to which all treatment, services or supplies provided by this plan are subject. For more comprehensive information about a particular benefit, please refer to the “Benefit Details” section of the plan.

Prevention And Health Management: The plan encourages you to obtain appropriate preventive care and to develop a lifestyle which promotes health and well being. We want you to reach your highest health potential! To assist you with taking personal accountability for your health, the plan provides the following:

- Comprehensive preventive care benefits.
- Case management programs to assist you with the management of serious and chronic illness.

Network Access: The plan has been designed to provide you with high quality benefits that are also affordable. When you use a **Port Huron Hospital** provider, your patient liability amounts will be less than they would be if you sought services from a **Regional PPO network** or **non-network provider**. Also, when you use a **network provider**, your patient liability amounts will be less than they would be if you sought services outside the network. This section fully explains how to find a **network provider**, the advantages of using **Port Huron Hospital** or **network providers**, and what happens if you are in an emergency situation and cannot use a **network provider**.

Plan Structure: The plan contains certain cost share responsibilities, such as **deductibles** and **out-of-pocket maximums** and provisions such as pre-certification which are outlined in this section of the plan. The information includes graphs and descriptions to help you fully understand how the plan is structured.

Benefit Details: When you do need medical services, this section describes the benefits available for each type of service – from Ambulance to X-ray. Benefits listed in this section are subject to the criteria outlined in the “What Is Covered?” and “What Is Not Covered?” sections of the plan.

Participating In The Plan: This section explains the plan’s eligibility requirements for you and your family members, when your coverage begins and ends, and what happens when you experience a change in status.

Other Important Information: This plan also provides general information regarding your rights to continue coverage, how this plan works with other coverage, how to submit claims and what to do if you disagree with a claim decision, as well as other information you may find helpful in understanding your benefits.

This plan is intended to comply with all provisions of any federal acts and/or applicable court decisions which set forth a precedent. This plan shall be deemed to be amended to minimum standards required by these acts and/or applicable court decisions, as interpreted by the **Plan Administrator**.

Having a benefit plan to provide support in assisting you and your eligible family members with maximizing health and to provide benefits during a time of **illness** and **injury** is a significant advantage that also comes with responsibility. Remember that you have the responsibility to:

- Learn more about your health and about this health plan.
- Help make decisions about your health care.
- Give your **physicians** the best information that you can about your health so they can help you get the care you need.
- Follow your **physician's** instructions about your health care.
- Focus now on living a healthy lifestyle!

We look forward to serving you! If you have questions about this plan or about your health care or need additional information, please do not hesitate to contact NGS.

NGS
P.O. Box 7676
St. Clair Shores, MI 48080
(800) 521-1555

For your convenience, you may also visit the NGS website at www.ngs.com.

On the website, you can access your enrollment and claims information at any time of the day or night through the NGS Self-Service Infocenter. Simply click on the "Self-Service Infocenter" and follow the three simple steps to register. On this site, you will have access to:

- Received, pending and paid claims.
- **Deductible**, out-of-pocket and maximum accumulations.
- Searchable Network directory information.

...and much more! If you need assistance with registering, you can contact our Help Desk at (877) 938-8875.

Important Phone Numbers

Name	Telephone Number
Your Doctor (primary care):	
Your Doctor:	
Your Doctor:	
Your Hospital:	
Your Pharmacy:	
Your Medications	
Important Contact Information	
NGS	1-800-521-1555
Port Huron Hospital Pharmacy Place	1-810-989-3455
Port Huron Hospital Pharmacy Benefit Administrator: Pharmacy Data Management, Inc.	1-800-800-7364
Precision Rx Specialty Injectables and Infusibles	1-800-870-6419
Medicare Helpline For help with questions about Medicare .	1-800-MEDICARE (1-800-633-4227) TTY 1-877-486-2048
Social Security Administration For help with questions about eligibility for and enrolling in Medicare , Social Security retirement benefits, or disability benefits.	1-800-772-1213 TTY 1-800-325-0778

TABLE OF CONTENTS

OVERVIEW OF BENEFITS	7-15
OVERVIEW OF BENEFITS: BENEFIT CRITERIA	16-18
PREVENTION AND HEALTH MANAGEMENT	19-20
How Will I Know If My Care Is “Preventive Care”?	19
Who Needs Wellness?... You Do!	19
What Is Covered?.....	19-20
NETWORK ACCESS	21-24
Why Is Having A “Family” Physician Important?	21
What Is A Network Provider?	21
How Will I Benefit From Choosing A Network Provider?	21
How Do I Locate Network Providers In My Area?	21
How Will I Benefit From Choosing Port Huron Hospital?	22
Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?	22
What Happens If I Do Not Use Port Huron Hospital?	23-24
PLAN STRUCTURE	25-30
What Is The Plan Deductible?	25
What Is Your Out-Of-Pocket Maximum?	25-26
Why Do I Get So Many Bills?.....	26
Does This Plan Have A Pre-Verification Provision?.....	27
Do I Need To Get A Pre-Verification?.....	27
How Does The Pre-Verification Process Work?.....	27
Verification Before Services Are Rendered – Non-Urgent Care Claims.....	28
Verification During Your Hospital Stay.....	28
Verification After A Hospital Stay	29
What If My Provider And I Disagree With The Decision?.....	29-30
Case Management.....	30
BENEFIT DETAILS	31-42
Working With Your Physician.....	31
What If I Need Diagnostic Testing?	32
Preparing For Diagnostic Testing.....	32
What Is Covered?	33
What If I Need Emergency Treatment?	34
Be Prepared For A Possible Emergency	34
Urgent Or Emergency Care Centers.....	35
What Is Covered?	35
What If I Need To Be Admitted To The Hospital?	36
What Is Covered?	36
What If I Need Skilled Nursing Or Rehabilitative Care?	37
Skilled Nursing Or Rehabilitative Care.....	37
What Is Covered?	37
Home Health Care	38
What Is Covered?	38
Hospice Care	39
What Is Covered?	39
What If I Need Rehabilitative Therapy?	40
What Is Covered?	40

What If I Am Going To Have A Baby?	41
Yes! You Can Help Improve The Health Of Your Pregnancy!	41
What Is Covered? - Mother's Expenses	41
What Is Covered? - Newborn's Expenses	42
You Should Know	42
DISEASE SPECIFIC TREATMENTS	43-58
What If I Need Chemotherapy?	43
What Is Covered?	43
What If I Need Dialysis?	43
What Is Covered?	43
What If I Need To See A Physician?	44
Preparing For A Physician Visit	44
What Is Covered?	45
What Is A Consultation?	45
What Is Covered?	45
What If I Need Surgery?	46
Preparing For Surgery	46
What Is Covered?	46-47
Second Surgical Opinions	47
Women's Health And Cancer Rights Act	47
What If I Need Anesthesia?	48
Weight Management	49
What Is Covered?	50
What Is Not Covered?	50
What If I Need A Transplant?	51
Preparing For A Transplant	51
Your Transplant Network	51
What Is Covered?	52
What Is Not Covered?	52
What If I Need A Prescription Medication?	53
Four Ways To Make Your Medications Work For You	53-54
Purchasing Decisions About Prescription Medications	55-56
What Is Covered?	56
What Is Not Covered?	56
What If I Need A Specialty Injectable Or Infusible Medication In My Physician's Office?	57-58
SUPPLEMENTARY SERVICES AND SUPPLIES	59-60
Medical Equipment, Medical Supplies, Orthotics And Prosthetics	59
What Is Covered?	59-60
WHAT IS NOT COVERED?	61-66
COORDINATION OF BENEFITS (COB)	67-72
How Does Coordination Work?	67
How Does The Plan Coordinate Benefits When Multiple Preferred Provider Arrangements Are Utilized?	68
Determining The Order Of Benefit Payments	68
Other Instances Where The Plan Coordinates Benefits With Other Coverages	69-71
Coordination Of Benefits With Medicare	71
Coordination Of Benefits With Auto Insurance Policy	72
PARTICIPATING IN THE PLAN (Eligibility, Changes In Family Status, etc.)	73-82
GLOSSARY	83-90

COBRA CONTINUATION COVERAGE	91
What Is COBRA?	91
When Would I Qualify For COBRA?	91
What Other Facts Should I Know Regarding My Rights Under COBRA?	91
Who Should I Contact For Further Information And To Whom Should I Provide Notice Of COBRA Events?	91
HIPAA PRIVACY RULES	92-94
Protected Health Information (PHI)	92
Use And Disclosure Of PHI	92
Your Rights Under HIPAA	92
Separation Of Plan And Plan Sponsor	93
Privacy Policy Changes	94
HELP FIGHT FRAUD	95
Detection Tips	95
Prevention Tips	95
Who Do I Contact If I Suspect Fraud, Waste Or Abuse?	95
HOW TO FILE MEDICAL CLAIMS	96-99
A General Overview	96
What Should You Know About Pre-Service Claims?	96
Plan Procedures For Filing A Pre-Service Care Claim	96
Urgent Care Pre-Service Claims	97
Non-Urgent Care Pre-Service Claims	97
What Should You Know About Post-Service Claims?	98
Plan Procedures For Filing A Post-Service Claim	98
Required Information	98
Providing Additional Information	99
Time Periods For The Plan And You	99
ADVERSE BENEFIT DETERMINATIONS AND APPEALS	100-101
What If My Claim Is Denied?	100
How Do I File An Appeal?	100-101
Is The Decision On Review Final?	101
FACILITY OF PAYMENT	102
REIMBURSEMENT OF PLAN PAYMENTS	103-104
GENERAL PLAN INFORMATION	105-106
YOUR RIGHTS UNDER ERISA	107
What Are My Rights Under ERISA?	107
DESIGNATION OF FIDUCIARY RESPONSIBILITY	108-110
Who Are The Fiduciaries Of The Plan?	108
What Are The Fiduciaries' Responsibilities?	108
What If The Plan Is Modified, Amended Or Terminated?	109
Who Is Responsible For The Administration Of The Plan?	109
How Is The Plan Funded?	109
Is This Plan Considered Health Insurance?	110

OVERVIEW OF BENEFITS

The plan is designed to provide levels of benefits based on the choices you make. Benefits that are payable are subject to the terms and conditions of the plan as indicated in the following pages.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Deductible						
• Individual	\$150	\$400	\$800	\$350	\$800	\$1,600
• Family	\$300	\$800	\$1,600	\$700	\$1,600	\$3,200
Deductibles do not cross-apply, except the Regional PPO network deductible does apply to the Port Huron Hospital and Affiliates deductible .						
Out-Of-Pocket (Including deductible)						
• Individual	\$750	\$2,000	\$4,000	\$1,500	\$3,000	\$5,000
• Family	\$1,500	\$4,000	\$8,000	\$3,000	\$6,000	\$10,000
Out-of-pocket amounts do not cross-apply, except the Regional PPO network out-of-pocket does apply to the Port Huron Hospital and Affiliates out-of-pocket .						
Lifetime Maximum, excluding Rx	\$1,000,000			\$1,000,000		
Hospital-Inpatient						
• Facility	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
• Physician	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Hospital-Outpatient						
• Facility – Surgery	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
• Facility – All Other Medical Conditions	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
• Physician	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Surgery						
• Facility	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
• Physician	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital and Affiliates** benefit level. Please refer to the section titled “Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?” for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Emergency Room						
<ul style="list-style-type: none"> Life-Threatening Illness/Accidental Injury – Facility and Emergency Room Physician and Radiologist 	100% after \$45 co-pay	100% after \$45 co-pay	100% after \$45 co-pay	100% after \$70 co-pay	100% after \$70 co-pay	100% after \$70 co-pay
<ul style="list-style-type: none"> Life-Threatening Illness/Accidental Injury – All physician charges (including consultations) except Emergency Room physician and Radiologist 	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
<ul style="list-style-type: none"> All Other Medical Conditions – Facility and Physician 	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Urgent Care	100% after \$25 co-pay	100% after \$25 co-pay	100% after \$25 co-pay	100% after \$35 co-pay	100% after \$35 co-pay	100% after \$35 co-pay
Ambulance						
<ul style="list-style-type: none"> Life-Threatening Illness/Accidental Injury 	90% after deductible	90% after deductible	90% after deductible	80% after deductible	80% after deductible	80% after deductible
<ul style="list-style-type: none"> All Other Medical Conditions 	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Anesthesia	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Blood						
<ul style="list-style-type: none"> Inpatient 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
<ul style="list-style-type: none"> Outpatient 	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Cardiac Rehabilitation	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
	Covered services performed through Partners at Heart, including St. Joseph Mercy Port Huron, will be paid at the Port Huron Hospital and Affiliates level.					

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled “Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?” for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Chemotherapy • Inpatient • Outpatient Hospital	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
IMPORTANT: Please refer to the section titled "What if I Need a Specialty Injectable Medication In My Physician's Office?" for information regarding benefits applicable to chemotherapy medications not provided by a hospital .						
Chiropractic Care (Maximums: \$30 per visit; \$600 in a calendar year; \$3,000 in a lifetime)	N/A	80% after deductible	70% after deductible	N/A	70% after deductible	60% after deductible
Consultations • Inpatient • Outpatient (i.e. second surgical opinion)	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
	100% after \$15 co-pay	100% after \$20 co-pay	70% after deductible	100% after \$20 co-pay	100% after \$25 co-pay	60% after deductible
The following applies to the inpatient consultation benefit described above. If services are rendered at Port Huron Hospital and a consultation is provided, it will be paid at the Port Huron Hospital and Affiliates level. If services are rendered at a Regional PPO network hospital , consultations will be paid at the Regional PPO network level, unless the physician is a Regional PPO network member who is a Port Huron Hospital medical staff member, then the consultation will be paid at the Port Huron Hospital and Affiliates level. If services are provided in a Non-Network hospital , consultations will be paid at Non-Network level for Non-Network physicians , the Regional PPO network level for Regional PPO network members, and the Port Huron Hospital and Affiliates level for physicians who are Port Huron Hospital medical staff members.						
Dialysis • Inpatient • Outpatient	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Home Health Care (Maximum: 90 visits in a calendar year)	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
For purposes of determining this benefit, a visit by each nurse or therapist and a visit by a home health aide of up to 4 hours constitutes one visit.						
Hospice	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital and Affiliates** benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Implants <ul style="list-style-type: none"> Inpatient or Outpatient Facility Fees All Other Expenses (including, but not limited to, charges for the implant, surgeon fees, anesthesia, etc.) 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
Infertility	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
Injections <ul style="list-style-type: none"> Inpatient Outpatient 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
	IMPORTANT: Please refer to the section titled "What if I Need a Specialty Injectable Medication In My Physician's Office?" for information regarding benefits applicable to certain injectable medications.					
Laboratory Testing <ul style="list-style-type: none"> Inpatient or Outpatient Surgery Hospital Facility Charges All Other Outpatient Services 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
Medical Equipment	90% after deductible	70% after deductible	50% after deductible	80% after deductible	60% after deductible	40% after deductible
Medical Supplies	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Mental Disorders and/or Substance Abuse Expenses <ul style="list-style-type: none"> Inpatient- Facility Inpatient- Physician Outpatient <ul style="list-style-type: none"> Office Visits All Other Outpatient Services 	100% 90% after deductible 100% after \$15 co-pay 90% after deductible	80% after deductible 80% after deductible 100% after \$20 co-pay 80% after deductible	70% after deductible 70% after deductible 70% after deductible 70% after deductible	90% after deductible 80% after deductible 100% after \$20 co-pay 80% after deductible	70% after deductible 70% after deductible 100% after \$25 co-pay 70% after deductible	60% after deductible 60% after deductible 60% after deductible 60% after deductible
Occupational Therapy <ul style="list-style-type: none"> Inpatient Outpatient (Maximum: 60 visits in a calendar year, combined with physical and speech therapy) 	100% 90% after deductible	80% after deductible 80% after deductible	70% after deductible 70% after deductible	90% after deductible 80% after deductible	70% after deductible 70% after deductible	60% after deductible 60% after deductible
Office Visits <ul style="list-style-type: none"> Office visits including those at the same time as a surgical procedure but for a different diagnosis Office visits at the same time as a surgical procedure for the same diagnosis (up to the reasonable and customary allowance) Physician home visits 	100% after \$15 co-pay 90% after deductible 90% after deductible	100% after \$20 co-pay 80% after deductible 80% after deductible	70% after deductible 70% after deductible 70% after deductible	100% after \$20 co-pay 80% after deductible 80% after deductible	100% after \$25 co-pay 70% after deductible 70% after deductible	60% after deductible 60% after deductible 60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Orthotics	90% after deductible <i>Limited to covered molded orthotics</i>	80% after deductible	50% after deductible	80% after deductible <i>Limited to covered molded orthotics</i>	70% after deductible	40% after deductible
Physical Therapy						
• Inpatient	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
• Outpatient (Maximum: 60 visits in a calendar year, combined with occupational and speech therapy)	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Post Mastectomy Supplies	90% after deductible	70% after deductible	50% after deductible	80% after deductible	60% after deductible	40% after deductible
Pregnancy Related Expenses-Mother						
• Covered Inpatient Hospital Facility Charges	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
• All Other Services	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN	COMPREHENSIVE PLAN
Prescription Drugs		
<u>Port Huron Pharmacy Place</u>		
• 30-Day Supply		
– Tier 1	\$7.50	\$12.50
– Tier 2	20% of total charge, subject to a minimum co-pay of \$15 and maximum co-pay of \$60	30% of total charge, subject to a minimum co-pay of \$20 and maximum co-pay of \$65
– Tier 3	30% of total charge, subject to a minimum co-pay of \$50 and maximum co-pay of \$100	40% of total charge, subject to a minimum co-pay of \$55 and maximum co-pay of \$105
• 3-Month Supply (Maintenance Drugs)		
– Tier 1	\$18.75 (2.5 times the 30-day co-pay)	\$31.25 (2.5 times the 30-day co-pay)
– Tier 2	2.5 times the 30-day co-pay, subject to a minimum co-pay of \$37.50 and a maximum co-pay of \$150	2.5 times the 30-day co-pay, subject to a minimum co-pay of \$50.00 and a maximum co-pay of \$162.50
– Tier 3	2.5 times the 30-day co-pay, subject to a minimum co-pay of \$125 and maximum co-pay of \$250	2.5 times the 30-day co-pay, subject to a minimum co-pay of \$137.50 and maximum co-pay of \$262.50
<u>Other Pharmacies</u>		
• 30-Day Supply		
– Tier 1	\$15	\$25
– Tier 2	30% of total charge, subject to a minimum co-pay of \$30 and maximum co-pay of \$100	40% of total charge, subject to a minimum co-pay of \$40 and maximum co-pay of \$110
– Tier 3	40% of total charge, subject to a minimum co-pay of \$60 and maximum co-pay of \$150	50% of total charge, subject to a minimum co-pay of \$70 and maximum co-pay of \$160
• 3-Month Supply (Maintenance Drugs)	Not Covered	Not Covered
Annual Maximum	\$25,000 in a calendar year	\$22,500 in a calendar year
	Please note that specialty injectable and infusible medications must be filled through the PrecisionRx Specialty Solutions Program. Specific information regarding this program and the benefits payable under this program can be found in the section titled "What If I Need a Specialty Injectable Medication In My Physician's Office?"	

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Preventive Care <ul style="list-style-type: none"> Routine Physical Routine Testing Well Baby/Child Immunizations Mammograms Routine Colonoscopies or Sigmoidoscopies <p>(Maximums: Comprehensive Plus Plan: \$500 in a calendar year; Comprehensive Plan: \$350 in a calendar year)</p>	100%	100%	70% after deductible	100%	100%	60% after deductible
Prosthetic Devices	N/A	80% after deductible	50% after deductible	N/A	70% after deductible	40% after deductible
Radiation Therapy <ul style="list-style-type: none"> Inpatient Outpatient 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
Skilled Nursing or Rehabilitative Facility <ul style="list-style-type: none"> Facility Services Physician Services <p>(Maximum: 120 days in a calendar year)</p>	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network	Port Huron Hospital and Affiliates*	Regional PPO Network	Non-Network
Speech Therapy <ul style="list-style-type: none"> Inpatient Outpatient (Maximum: 60 visits in a calendar year, combined with occupational and physical therapy) 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
Transplants <ul style="list-style-type: none"> Facility Physician (Maximums: \$1,000,000 in a lifetime [included in the lifetime maximum]; \$10,000 for travel, meals and lodging, up to \$40 per day, covered only when an OptumHealth provider is used) 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
Weight Management	75% after deductible	Not Covered	Not Covered	Not Covered	Not Covered	Not Covered
X-Rays <ul style="list-style-type: none"> Inpatient or Outpatient Surgery Hospital Facility Charges All Other Outpatient Services 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible
All Other Covered Expenses <ul style="list-style-type: none"> Inpatient Outpatient 	100%	80% after deductible	70% after deductible	90% after deductible	70% after deductible	60% after deductible

* Certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. Please refer to the section titled "Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?" for specific information.

NOTE: Any maximums listed are applicable to all plan options. If a new plan option is elected, any amounts applied toward the maximums in the current/previous plan option will be applied to the new plan option. Plan maximums do not start over when a new plan option is elected.

OVERVIEW OF BENEFITS: BENEFIT CRITERIA

You need to know that this plan provides coverage for treatment, services and supplies that meet certain criteria. FOR CHARGES TO BE CONSIDERED FOR PAYMENT UNDER THIS PLAN, THE TREATMENT, SERVICE OR SUPPLY:

1. MUST BE **MEDICALLY NECESSARY** (OR BE PREVENTIVE),
2. MUST BE RENDERED BY A COVERED PROVIDER/FACILITY,
3. MUST NOT EXCEED **REASONABLE AND CUSTOMARY** AMOUNTS,
4. MUST NOT BE CONSIDERED **EXPERIMENTAL/INVESTIGATIONAL**, AND
5. MUST NOT BE LIMITED, RESTRICTED OR EXCLUDED ELSEWHERE IN THIS **SUMMARY PLAN DESCRIPTION (SPD)**.

These criteria, which are explained below, are admittedly very technical. It is not our intention to confuse you. Instead, we would like to assist you with understanding how these provisions relate to your proposed course of treatment. You and/or your **physician** should feel free to contact NGS for additional clarification on any of the provisions listed below.

1. When Is A Procedure, Service Or Supply Considered Medically Necessary?

A procedure, service or supply is deemed to be **medically necessary** when it is for the treatment of an **illness** or **injury**; it is prescribed by a **physician** and is professionally accepted as the usual, customary and effective means of treating a condition. Diagnostic x-rays and laboratory tests that are performed due to definite symptoms of **illness** or **injury** or reveal the need for treatment will be considered **medically necessary**. In the evaluation of medical necessity, the plan may request records that, if legally required to be maintained, must be made available to the plan in order to consider the expenses. The plan may also seek outside medical opinions from appropriate board certified specialists. The plan reserves the right to have the patient examined by an independent specialist in the appropriate field of medicine.

2. Who Is A Covered Provider?

A provider shall be considered a covered provider if he or she is a provider listed in the definition of "**physician**," "**hospital**," "**skilled nursing facility**," "**hospice**" or "**home health care agency**" (Please see the "Glossary") acting within the scope of his or her license. Additionally, the plan will cover other providers who are not **physicians** but who are specifically mentioned as covered providers in this **SPD**, provided they are acting within the scope of their license.



3. What Is Meant By “Reasonable And Customary”?

“**Reasonable and Customary**” (R&C) refers to certain plan limitations on provider charges, in regard to what will be accepted as allowable under the plan. As the actual purchaser of health care services, you should not hesitate to seek information from medical providers on the cost of proposed treatments for you and your family members, just as you would if you were making any other type of purchase. While the plan has contracted with a Preferred Provider Network (PPO) to pre-arrange negotiated rates with **network providers**, charges over R&C will be denied for **non-network providers** and certain aspects of R&C calculations may also still impact what the plan will reimburse on a network claim. By playing an active role in seeking cost information, you can minimize your own out-of-pocket costs and conserve the dollars applied to any maximums under the plan as well. In general, R&C means that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered. **Reasonable and customary** calculations also use standard methods to adjust for unusual circumstances or complications which may require additional time, skill or experience.

For out-of-network services, charges are screened against commercial databases comprised of aggregated data collected from all health plan payers or other normative data derived from sources such as **Medicare** cost to charge ratios, average wholesale price data for prescriptions, and/or manufacturer’s retail pricing for certain supplies and devices. If you use a **non-network provider**, you will be responsible for all amounts in excess of R&C and these amounts may be substantial. For out-of-network professional services (service provided by an individual practitioner), R&C shall mean that the charge is comparable to fees charged for the same or similar services in the geographic area where the service is rendered.

With in-network professional services (services provided by an individual practitioner), R&C is the fee agreed to by the participating provider as long as your provider adheres to standard billing practices.

All (both in- and out-of-network) health care practitioners must bill the plan using CPT codes to indicate services performed. CPT codes were developed by and are maintained by the American Medical Association. Along with assigning codes to particular services, the AMA has established guidelines for billing and reimbursement. For example, when more than one surgical procedure is performed in the same operative session, CPT rules limit reimbursement on secondary procedures to 50% of the amount that would normally be reimbursable for that code. This plan’s reimbursement will follow CPT guidelines. You should confirm with your provider, whether in-network or out-of network, that his or her practice follows the AMA’s CPT coding guidelines to ensure that you do not have a liability for amounts over R&C.

4. What Is Meant By “Experimental” Or “Investigational”?

The plan will consider a drug, device, supply, treatment, procedure or service to be “**experimental**” or “**investigational**”:

- a. if the drug, device, supply, treatment, procedure or service cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given for the proposed use at the time the device or supply is furnished; or
- b. if the drug, device, supply, treatment, procedure or service, or the patient’s informed consent document utilized with respect to the drug, device, supply, treatment, procedure or service was reviewed and approved by the treating facility’s institutional review board or other body serving a similar function, or if federal law requires such review or approval; or
- c. if the drug, device, supply, treatment, procedure or service is the subject of on-going phase I or phase II clinical trials, or is the research, **experimental** or **investigational** arm of on-going phase III clinical trials; or
- d. if based on documentation in one of the standard reference compendia or in substantially accepted peer-reviewed medical literature that the prevailing opinion among experts regarding the drug, device, supply, treatment, procedure or service is that further studies or clinical trials are necessary to determine its maximum tolerated dose, toxicity, safety or efficacy.

Exception: An FDA approved drug that meets the criteria set under **reliable scientific evidence** will not be deemed **experimental**.

5. What Is Excluded Under The Plan?

The plan excludes payment for certain treatment, services or supplies in the form of limitations or maximums, subject to the criteria listed above, the general exclusions listed in the exclusions section at the back of the document, and specific benefit exclusions described under the benefit details section of this plan. When determining if a particular treatment, service or supply is payable, it is important to first consider the criteria listed above, then review the benefit details and general exclusions to determine if any limitations, maximums or exclusions apply.

Important Plan Note Regarding Physical Examinations:

This plan, at its own expense, will have the right and opportunity to have any individual whose medical or **dental** treatment is the basis of a claim under this plan, examined by a **physician** designated by this plan when and as often as it may be reasonably required during the review of a claim under this plan.

PREVENTION AND HEALTH MANAGEMENT

“An ounce of prevention is worth a pound of cure.” Making preventive care a priority in your life can be difficult, but it is always worthwhile. Many of today’s most debilitating health conditions such as heart disease, cancer, diabetes and chronic respiratory disease may be directly linked to lifestyle choices including tobacco use, physical inactivity, poor nutrition, and excessive alcohol consumption. The solution seems simple...adopt a healthy lifestyle, and avoid preventable health conditions...but changing our daily behaviors can be extremely difficult. Port Huron Hospital’s health plan has been designed to support you and your family each step of the way as you make wellness a central part of your lives.

How Will I Know If My Care Is “Preventive Care”?

Many people are confused about when their care is considered “preventive” and when their care is considered “diagnostic”. While each situation is different, a general rule of thumb is treatment for *personal* history or symptoms will be considered “diagnostic” care or treatment. Treatment for *family* history or symptoms is considered “preventive” care or treatment.

Who Needs Wellness?...You Do!

Wellness is important for every person, at every age and of every health status, but our specific needs are very different. For that reason, Port Huron Hospital’s preventive care benefits offer you flexibility - you and your **physician** determine what services are best for you. The plan, in conjunction with Port Huron Hospital’s other preventive programs, also offers you guidance - to help you manage your health and use your benefits wisely.

What Is Covered?

This plan provides the following preventive benefits for you and your covered **dependents**, subject to the annual maximum described in the “Overview of Benefits”:

- Annual routine health examinations (including school exams) and related laboratory testing and x-rays as recommended by your **physician**.
- Well baby/well child examinations and related laboratory test and x-rays as recommended by your **physician**.
- Child immunizations in accordance with the current year’s childhood immunization schedule published by the American Academy of Pediatrics. Refer to www.cisimmunize.org for a current online schedule.
- Adult immunizations.



- Cancer screening examination(s) and related laboratory testing and x-rays as recommended by your **physician** including, but not limited to gynecological exam and related pap smear, PSA test, sigmoidoscopy, colonoscopy, fecal occult blood test, digital rectal exam, mammograms.
 - Preventive/routine screening colonoscopy and/or flexible sigmoidoscopy, starting from age 50 and allowing one every five years thereafter. This plan will pay for a routine screening colonoscopy for individuals under age 50 if there is a history of colon cancer in the immediate family, then one thereafter every five years if there are not findings, or one annually if **medically necessary**.

NOTE: Routine sigmoidoscopy and colonoscopy services are paid at the same benefit level as **medically necessary** sigmoidoscopies and colonoscopies, and will not apply to the annual maximum for preventive services.

NETWORK ACCESS

Why Is Having A “Family” Physician Important?

Managing your family’s healthcare, from both a medical and financial perspective, can be a difficult and complicated process. Your family **physician** is your partner in navigating that process. He or she coordinates the care your family receives as well as the providers that render that care. Seeing your family **physician** regularly keeps him or her well informed about your health and allows you and your **physician**, together, to make the best possible choices about the treatment your family receives, regardless of plan coverage.

What Is A Network Provider?

A **network provider** is a facility or practitioner who has a signed contract with a preferred provider network (PPO) to provide medical services at a specific rate or pay. **Network providers** are independent contractors and the plan does not provide any guarantee concerning the care provided by **network providers**.

How Will I Benefit From Choosing A Network Provider?

Port Huron Hospital has contracted with **Regional PPO networks** to be the plan's **network provider** along with Port Huron Hospital. **Regional PPO networks** and their providers are independent contractors. Port Huron Hospital does not provide any guarantee concerning the care provided by **network providers**. You, together with your **physician**, are ultimately responsible for determining the appropriate treatment, regardless of coverage by this plan. Copies of the PPO provider directories can be obtained online.

When you or your covered **dependent(s)** choose a **Regional PPO network provider**, the plan will pay a higher level of benefits than a **non-network provider** and the benefit level will be lower than if services are provided at Port Huron Hospital (except as otherwise stated in the section titled “What Happens If I Do Not Use Port Huron Hospital?”).

How Do I Locate Network Providers In My Area?

To locate **network providers** in your area, simply log onto the NGS website (www.ngs.com) and click on “Find a Provider.” You may search for a provider by specialty, location or distance. You may also contact NGS at (800) 521-1555.



How Will I Benefit From Choosing Port Huron Hospital?

In most cases, when you or your covered **dependents** choose **Port Huron Hospital** or one of its affiliates, the plan will pay at the highest level of benefits. In addition, the services provided will be subject to a lower **deductible**, as well as a lower **out-of-pocket maximum**. So, your share of the cost will be lower when you choose **Port Huron Hospital** or any one of its affiliates. Please note that there are some instances where you must use **Port Huron Hospital** (not an affiliate) in order to receive the highest level of benefits. Those situations are described in the section titled "What Happens If I Do Not Use Port Huron Hospital?".

Are There Any Services That Must Be Rendered At Port Huron Hospital In Order To Receive The Port Huron And Affiliates Level Of Benefits?

Yes. Certain services must be rendered at **Port Huron Hospital** (if available) in order to receive the **Port Huron Hospital** and Affiliates level of benefits. These services are as follows: laboratory testing (excluding allergy testing), neurological testing, occupational therapy, physical therapy, pregnancy related expenses billed outside of the global billing fee, speech therapy, surgery fees and all related expenses when the surgery requires more than a topical or local anesthetic, sleep center services, and imaging services and their interpretation (e.g., x-rays, echocardiograms, ultrasounds, MRI/MRA, PET/Cat Scans, etc.). Please note that radiologists who are contracted with Port Huron Hospital will always be paid at the **Port Huron Hospital** and Affiliates level when interpreting imaging services provided at Port Huron Hospital.

So, if you receive any of the above services in your **physician's** office or at any other **Port Huron Hospital** affiliate, you will not receive the **Port Huron Hospital** and Affiliates level of benefits. Rather, the plan will pay benefits at the **Regional PPO network** or Non-Network level, depending upon the provider's network status.

What Happens If I Do Not Use Port Huron Hospital?

If:	Then:
<p>You or your dependent need emergency treatment for an accidental bodily injury or a life-threatening medical emergency and receive treatment at a Regional PPO network or Non-Network facility</p>	<p>Benefits will be paid at the Port Huron Hospital and Affiliates level.</p>
<p>You or your dependent utilize a non-network provider and such specialty provider and/or service is not available through Port Huron Hospital or a Regional PPO network provider</p>	<p>Benefits will be paid at the Port Huron Hospital and Affiliates level. Benefits for any related lab tests, x-rays or follow-up visits rendered by the referred non-network provider, when such lab tests, x-rays or follow-up visits are not available through Port Huron Hospital, will be paid at the Port Huron Hospital and Affiliates level.</p>
<p>You or your dependent utilize a Regional PPO network provider for an inpatient stay or an outpatient procedure, and the service or supply is <u>not</u> available through Port Huron Hospital</p>	<p>Benefits will be paid at the Port Huron Hospital and Affiliates level. Benefits for any related lab tests and x-rays not performed at the same time as the procedure or follow-up visits rendered by the Regional PPO network provider, when such lab tests, x-rays or follow-up visits are <u>not</u> available through Port Huron Hospital, will also be paid at the Port Huron Hospital and Affiliates level.</p> <p>This increased benefit will not apply to any pre-admission testing. In addition, this increased benefit will not apply for any procedures performed by a Regional PPO network provider when Port Huron Hospital provides a procedure which can be used to treat or diagnose your condition but you elect the procedure performed by the Regional PPO network provider.</p> <p>This provision will also apply to adolescent mental health or substance abuse services when the child's Regional PPO network psychiatrist requests that the patient be seen by a mental health professional within his or her practice. In that instance, benefits will be paid at the Port Huron Hospital and Affiliates level. If the treating psychiatrist is a non-network provider, all benefits will be paid at the Non-Network level.</p> <p>Finally, certain services are not eligible for an increased benefit level under this provision, and those services are as follows: chiropractic services, orthotics, prosthetics and genetic testing and/or genetic counseling.</p>

<p>You or your dependent utilize a non-network provider and such specialty provider and/or service is available through Port Huron Hospital or a Regional PPO network provider</p>	<p>Benefits (including any related laboratory tests, x-rays or follow-up visits by the same non-network provider) will be paid at the Non-Network level.</p>
<p>You or your dependent utilize Port Huron Hospital or a Regional PPO network facility for inpatient/outpatient services/ procedures, but the facility uses a Regional PPO network or non-network provider for anesthesia, the interpretation of laboratory tests and x-rays and other medically necessary services</p>	<p>If you utilize Port Huron Hospital for the inpatient or outpatient procedure, benefits will be paid at the Port Huron Hospital and Affiliates level. If you utilize a Regional PPO network facility for the inpatient or outpatient procedure, benefits will be paid at the Regional PPO network level.</p>
<p>You or your dependent are admitted to a Regional PPO network or Non-Network hospital through the emergency room because of an accidental bodily injury or a life-threatening medical emergency</p>	<p>Benefits will be paid at the Port Huron Hospital and Affiliates level.</p>
<p>When benefit payment to a non-network provider is upgraded to the Port Huron Hospital or Regional PPO network level of payment, the reasonable and customary allowance will be based on a similar service or medical procedure by most similarly qualified physicians or other health care providers in the geographic area where the service or medical procedure is rendered. Any expenses in excess of reasonable and customary will be your responsibility.</p>	



PLAN STRUCTURE

What Is The Plan Deductible?

The **deductible** is the specific dollar amount that you must pay (or “satisfy”) before the plan pays its share of covered charges each calendar year. The **deductible** is satisfied on a calendar year basis with expenses from January through December.

Your **deductible** varies based on the plan option you have elected and whether you choose to receive services from a **network** or **non-network provider**. For **deductible** amount(s) and other specific benefit information, please refer to the section titled “Overview of Benefits.”

The **Port Huron Hospital** and Affiliates **deductible** will not apply to the **Regional PPO network deductible** or the Non-Network **deductible**. The **Regional PPO network deductible** will apply to the **Port Huron Hospital** and Affiliates **deductible**, but not the Non-Network **deductible**. The Non-Network **deductible** will not apply to the **Port Huron Hospital** and Affiliates **deductible** or the **Regional PPO network deductible**.

Expenses that cannot be used to satisfy the plan’s calendar year **deductible** are:

- Plan co-pays
- **Prescription drug** expenses
- Services paid at 100%
- Services or supplies not covered by the plan

What Is Your Out-Of-Pocket Maximum?

This plan shares with you the expense for certain services. Your co-payment is the balance that you must pay of the **reasonable and customary** charge for covered benefits when payment is made at less than 100% after the applicable annual **deductible** has been met.

This plan is designed to limit your out-of-pocket expense. The **out-of-pocket maximum** limits are for covered services rendered during each calendar year. Your **out-of-pocket maximum** varies based on the plan option you have elected and whether you choose to receive services from a **network** or **non-network provider**. For **out-of-pocket maximum** amount(s) and other specific benefit information, refer to the section titled “Overview of Benefits.”

The **Port Huron Hospital** and Affiliates **out-of-pocket maximum** will not apply to the **Regional PPO network out-of-pocket maximum** or the Non-Network **out-of-pocket maximum**. The **Regional PPO network out-of-pocket maximum** will apply to the **Port Huron Hospital** and Affiliates **out-of-pocket maximum**, but not the Non-Network **out-of-pocket maximum**. The Non-Network **out-of-pocket maximum** will not apply to the **Port Huron Hospital** and Affiliates **out-of-pocket maximum** or the **Regional PPO network out-of-pocket maximum**.

For services rendered during the remainder of the calendar year after a **covered individual** reaches their **out-of-pocket maximum** limit, this plan will pay 100% of the **reasonable and customary** charges for subsequent expenses which would otherwise be paid at a percentage other than 100%, after satisfaction of the annual **deductible**.

Co-payments that cannot be used to satisfy the **out-of-pocket maximum** limit and not eligible for 100% payments even if the **out-of-pocket maximum** is met are:

- Plan co-pays
- **Prescription drug** expenses
- Benefits for durable medical equipment and post-mastectomy supplies at the **Regional PPO network** benefit level or the Non-Network benefit level
- Benefits for **orthotics** and prosthetics paid at the Non-Network benefit level
- Covered weight management services (Comprehensive Plus Plan only)
- Services or supplies not covered by the plan

Why Do I Get So Many Bills?

The above is possibly the most frequently asked question by those who receive medical services. Generally, many different health care providers work together to ensure that the highest possible level of care is provided.

You may receive bills from providers who are contracted by the **hospital**, such as anesthesiologists, residents or pathologists. Additionally, you may receive bills from providers who your **physician** asked to participate in your care, such as specialists who provide consultations. Finally, you will receive bills from the facility in which the services were performed, such as the **hospital** or surgical center.

You should review all of your bills. If you see a charge for a provider or service you do not remember, you should ask to review your records to verify that the service was provided.

Does This Plan Have A Pre-Verification Provision?

Your plan includes a feature called “pre-verification of benefits.” Pre-verification is the process of evaluating whether proposed services, supplies or treatments meet the medical necessity and other provisions of the plan to help ensure quality, cost effective care.

The intent of the pre-verification process is not to limit the patient’s choice of a provider, nor to tell the patient and the provider what treatment or services should be performed. The provider and patient may proceed with any treatment plan they may choose, regardless of the benefit determination under the pre-verification process, recognizing that the patient will be responsible for the additional cost incurred beyond the plan benefit.

Do I Need To Get A Pre-Verification?

This plan requires all **inpatient** admissions to be reviewed prior to your scheduled admission date. “**Inpatient** admissions” include **inpatient hospital** admissions, partial hospitalization, **hospice**, transplants and home health care. Should your admission be due to a need for *urgent care* and pre-verification cannot take place prior to admission, you, your **authorized representative**, or the **hospital** should call within 48 hours or the next business day, whichever is later, after admission occurs. Please note that no prior approval is needed if the patient needs medical care that would be considered *urgent care*. This provision also does not apply to childbirth admissions less than 48 hours for vaginal delivery or 96 hours for cesarean delivery, nor does it apply to services rendered/provided outside of the continental United States of America or any U.S. Commonwealth, Territory or Possession.

To verify your admission, you or your provider may call: (800) 521-1555

Please note that this plan does not reduce any available benefits if you fail to obtain pre-verification.

How Does The Pre-Verification Process Work?

There are different types of verifications that may be performed in connection with your treatment. Your specific circumstances will help determine which verification method is appropriate for your situation.

The following information should be provided when you or your provider request verification:

1. Your name, address, phone number, and identification number;
2. Your employer’s name;
3. If you are not the patient, the patient’s name, phone number, and address.
4. The admitting **physician’s** name and phone number;
5. The name of the **hospital** or facility;
6. Date of admission or proposed admission; and
7. The condition for which the patient is being admitted to the **hospital** or facility.

Verification Before Services Are Rendered – Non-Urgent Care Claims

If a request for a non-urgent care pre-verification is made providing the complete information described above, the necessary clinical information will be requested from the provider and the requesting person will be notified of the pre-verification determination within 15 days of receipt of the clinical information.

If all of the information listed above is not provided the requesting person will be notified, orally or in writing, within five days of receipt of the request. You or your provider must respond to that notification providing the information above within 15 days. If there is no response from you or your provider within these 15 days, the plan will deny the pre-verification. If further clinical information is needed, or there are matters that prevent a decision and they are beyond the control of the plan, the requesting person will be notified within 15 days. You or your provider will have up to 45 days from the request to supply the needed information. When the information is received, the requesting person will be notified of a determination within 15 days from the receipt of the response. If there is no response from you or your provider to the request for information, the pre-verification will be denied within 60 days after the request for information. Should the required information be submitted subsequently, it will be considered a new request and will be reviewed in accordance with the above guidelines.

Verification During Your Hospital Stay

If a late notification of an admission is received and your care is already ongoing, or you stay in the **hospital** longer than originally verified, what is referred to as “concurrent review” will be performed. So, while you are in the **hospital**, your treatment may continue to be reviewed to verify additional days of **hospital confinement**, other necessary treatment or discharge planning.

When a concurrent review is performed on an urgent request, the requesting person will be notified of a determination within 24 hours from receipt of the request, as long as the request was made at least 24 hours before the end of the last verified day.

If the request was made less than 24 hours prior to the end of the last verified day, and all necessary clinical information was provided, then the requesting person will be notified of a determination within 72 hours from receipt of the request. If additional information is needed, the process described under “Verification Before Services Are Rendered – Non Urgent Care Claims” will be followed.

When a concurrent review is performed on a non-urgent request, the requesting person will be notified of the verification determination as quickly as possible, but not later than 15 days from receipt of the request. If additional information is needed, the process described under “Verification Before Services Are Rendered – Non-Urgent Care Claims” will be followed.

Should the verification determine that the plan’s medical necessity provision will only allow a reduced **hospital** stay or shortened course of treatment before the end of any previously verified period, then you and your provider will be notified of the proposed change and you or your provider may appeal the change in the pre-verification determination. The decision on the appeal must be provided prior to the end of the previously verified period.

Finally, if at the end of a previously verified **hospital** stay it is determined that continued **hospital confinement** no longer meets the medically necessity provision of the plan, additional days will not be verified.

Verification After A Hospital Stay

When you or your provider do not obtain verification prior to receiving services, or if you are discharged from the **hospital** during the time between the request for verification and the receipt of necessary clinical information, a verification process called “retrospective review” will be completed.

When a retrospective review is performed, the requesting person will be notified of a decision as quickly as possible, but no later than 30 calendar days from receipt of the request.

If additional information is needed, you or your provider will be notified within 30 days. You will have up to 45 days from the request to supply the needed information. When the information is received, the requesting person will be notified of the retrospective review determination within 15 days from the receipt of the response. If you or your provider do not respond to the request for information, the plan will deny the retrospective review within 60 days after the request for information. Should the required information be submitted subsequently, it will be considered a new request and will be reviewed under the above guidelines.

What If My Provider And I Disagree With The Decision?

If you or your provider disagree with the verification decision, you have a few options. First, you and your provider may proceed with any treatment plan you may choose, regardless of the benefit determination. Second, you may be able to request reconsideration. And, finally, you may file an appeal.

If an initial determination is made that the proposed treatment does not meet the medical necessity provision of the plan and no “peer-to-peer” conversation has taken place between your attending **physician** and the independent reviewing **physician** who participated in the original determination, then the reconsideration process will be offered.

If your provider requests reconsideration within two business days of the adverse determination, a peer-to-peer conversation between your attending **physician** and the original independent reviewing **physician** (or an alternate **physician** with the same qualifications if the original reviewing **physician** is unavailable) will be arranged. The peer-to-peer conversation can occur by telephone, in person, or electronically, but it must occur within one business day following the request for reconsideration. If it cannot occur within 1 business day, you or your provider will still have the right to appeal the verification decision.

The requesting provider will be notified of the results of the peer-to-peer conversation and any change in the benefit determination within one business day of receipt of the information from the reviewing **physician**. If the conversation resulted in a verification that the treatment met the medical necessity provision of the plan, the verification process will proceed as described in the section “How Does the Verification Process Work?”. If the conversation does not change the original verification determination, a formal letter of explanation will be sent.

Appeals

If you or your provider disagree with any verification determination based upon medical necessity, you and/or your provider may appeal that decision within 180 days of the date of the adverse determination. The appeal may be made by telephone or in writing, via mail, facsimile, or electronically. You may submit written comments, documents, records, and other information relating to the treatment. The appeal and all supporting documentation should be submitted by calling the pre-verification number above. If you or your provider request, you will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the verification. A decision regarding the appeal of an urgent care determination will be provided to you and your provider within 72 hours. A decision regarding the appeal of a non-urgent care determination will be provided to you and your provider within 30 days.

If you or your provider disagree with any verification determination based upon any reason other than medical necessity, please refer to the section titled "What If I Receive an Adverse Benefit Determination?" for further information.

Case Management

The plan provides a **covered individual** the opportunity to receive medical case management services.

Medical case management is a program that manages the provision of healthcare to individuals with high cost medical conditions. The goal is to perform assessment, planning, facilitation and advocacy for options and services available to meet an individual's health needs. This process is performed through communication and coordination of available resources to promote quality cost-effective outcomes.

When it is determined that a case would benefit from case management, arrangements will be made for case review by a **nurse** coordinator from an independent case management firm. The **nurse** coordinator will contact the individual (and family) to assist with the individual's needs for coverage and benefit information, coordination of the services with health care providers, perform various services associated with a discharge or return home, provide patient education and make recommendations to the patient (family) concerning the types of services that can aid in the recovery process.

When the patient chooses to follow the recommendations made through case management, the plan may, at its discretion, cover additional **medically necessary**, non-experimental expenses.

BENEFIT DETAILS

Working With Your Physician

You and your **physician** are a team and your goal is to make sure you are in the best health possible. Both you and your **physician** have important responsibilities in helping the team reach its goal. You can work better with your **physician** by following 3 simple steps:

1. Ask

- Ask questions, especially if you do not understand your **physician's** or **nurse's** instruction.
- Let your **physicians** and **nurses** know if you need more time to ask questions about your health.

2. Tell

- Tell your **physician** your health history. Be sure to mention family history of diseases and conditions.
- Tell your **physician** about your health now. Only you know how you feel and whether you feel differently than you did before.
- Be sure to tell your **physicians** and **nurses** if you have any allergies or reactions to medicines.

3. Follow up

- Once you leave the **physician's** office, follow up.
 - If you have questions, call the **physician's** office.
 - If you have problems with your medicine, call your **physician** or your pharmacist.
 - If you need to see a specialist or get a test, make the appointment or ask your **physician's** office to make the appointment.
 - If you do not hear from your **physician** or **nurse** about test results, call and ask. If you do not understand the results, ask what they mean.

What If I Need Diagnostic Testing?

There are numerous reasons why you may need diagnostic testing. Diagnostic testing provides information needed to help your **physician** diagnose your condition, as well as prescribe, refer and monitor treatment of your condition.

Some diagnostic tests are invasive and require a perforation or incision into the skin or a body cavity to obtain a specimen (e.g., biopsy or catheterization). Other diagnostic tests are non-invasive (e.g., urine test, x-rays, CAT/MRI scans, etc.) This section addresses non-invasive diagnostic tests. See “What if I Need Surgery?” for more information regarding invasive tests.

The plan will pay for the diagnostic tests, including any charges associated with interpreting the results.

Preparing For Diagnostic Testing

If your **physician** orders diagnostic testing, you may want to ask your **physician** the following questions:

1. Why do I need the testing?
2. What do I need to do to prepare for the testing (e.g., diet, fasting, etc.)?
3. Should I take my medications/supplements before my testing?
4. Will the testing be painful or uncomfortable?
5. Who do I call to obtain my results?
6. How long will it take to receive my results?
7. What are the “normal” ranges of the testing?
8. If all my test results are normal, does that mean I have nothing to worry about?



What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Allergy tests.
- Laboratory testing, x-rays, and other diagnostic testing (e.g., CAT/MRI scans, EKGs, EMGs, EEGs, thyroid testing, nerve conduction studies, pulmonary functions studies, etc.) to diagnose an **injury** or **illness** (including charges associated with interpreting the results), when ordered by a **physician** and performed in a:
 - **hospital outpatient** department;
 - **hospital** emergency room to initially care for an accidental bodily **injury** or a **life-threatening medical emergency**;
 - **hospital** emergency room when related to a condition that does not qualify as an accidental bodily **injury** or a **life-threatening medical emergency**;
 - **physician’s** office;
 - urgent care center; or
 - laboratory or x-ray facility.
- Pre-admission tests performed in a **hospital outpatient** department, a **physician’s** office, or separate laboratory or x-ray facility performed within 14 days prior to a covered **hospital confinement** or **surgery**.
- X-rays (including the interpretation of the results) related and performed prior to a covered oral surgical procedure.
- Genetic testing when **medically necessary** to establish a **diagnosis** of an inheritable disease if the patient has clinical symptoms or is at direct risk of inheriting the disease and the results of genetic testing will directly impact the patient’s treatment and all other means of determining a definitive **diagnosis** have been exhausted. Genetic counseling unrelated to pregnancy will be covered when necessary in accordance with the American College of Medical Genetics. Genetic counseling in connection with pregnancy will be covered if:
 - the parents had a previous child born with a genetic disorder, **birth defect**, chromosome abnormality, mental retardation, autism, developmental delay or **learning disability**, or
 - the pregnancy is known to be at increased risk for complications or **birth defects** based on ultrasounds, screening tests, ethnicity, maternal age, exposure to external agents, known genetic disorder affecting either parent, previous stillbirths or repeat miscarriages and a suspicion of chromosome abnormalities, or closely related couples.

What If I Need Emergency Treatment?

Having to receive medical care in an emergency situation or in a situation which might be an emergency can be a scary and confusing time. The first thing to know is: IF YOU ARE IN A SITUATION THAT MIGHT REQUIRE IMMEDIATE CARE, YOU SHOULD RECEIVE MEDICAL TREATMENT AS QUICKLY AS POSSIBLE.

Be Prepared For A Possible Emergency

During an emergency you will need to act quickly. However, there are some things that you can do, in advance, to ensure that you receive the best care possible. Taking just a few minutes to prepare for a possible emergency can be beneficial in the long run.

1. Know the location of the closest emergency room.
2. Make sure all your family members know what to do in the case of an emergency.
3. Prominently display emergency contact information, including ambulance, fire and **physician's** numbers.
4. Keep a Personal Health History for each member of your family. Keep this history in your purse or wallet so you can bring it with you in the case of an emergency. This history will assist the emergency **physicians** with providing the best possible treatment and should include the following information.
 - I was in the **hospital** for (list conditions and dates):
 - I have had these **surgeries**:
 - I have had these **injuries/conditions/illnesses**:
 - I have these allergies (list type of allergy and reaction):
 - I have had these immunizations (shots):
 - I take these medicines/supplements (bring with you, if possible):
 - My family members (parents, brothers, sisters, grandparents) have/had these major conditions:
 - I see these other health care providers (include the name and phone number for each provider, as well as why you see them):

Urgent Or Emergency Care Centers

What if you get sick at night, on a holiday, or over the weekend? You can not get to your **physician**, but you are not sick enough to go to the emergency room. There may be an "urgent" or "emergency" care center near you. These centers are open long hours every day to handle problems that are not life-threatening. But they are no substitute for a regular primary care **physician**.

To make sure an urgent or emergency care center provides quality care, call or visit the center to find out:

1. If the center is licensed. Then check to see if it is accredited by a group such as The Joint Commission (telephone: 630-792-5800; website: <http://www.jointcommission.org>) or the Accreditation Association for Ambulatory Healthcare (telephone: 847-853-6060; website: <http://www.aaahc.org>). The accreditation certificate should be posted in the facility.
2. How well trained and experienced are the center's **health care professionals**?
3. If the center is affiliated with a **hospital**. If it is not, find out how the center will handle any emergency that could happen during your visit.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled "Overview of Benefits":

- The plan pays benefits for professional ambulance services (ground, sea, or air) for transportation to treat an accidental bodily **injury**, a **life-threatening medical emergency**, or any other medical condition. Covered transportation will be to the closest facility equipped to handle the condition. The plan also covers ambulance transportation to a **skilled nursing facility** or **hospice facility**, from a Non-Network **hospital** to a **Regional PPO network hospital**, or between **hospitals** when a patient needs immediate testing or when other treatments cannot be performed by the **hospital** in which the patient is confined. Transportation from the **hospital** to the patient's home.
- The plan pays benefits for a **hospital** emergency room, including **physician** and covered facility charges to initially treat an accidental bodily **injury** (within 72 hours) or a **life-threatening medical emergency** (within 24 hours). The plan also pays benefits for a **hospital** emergency room to treat a medical condition which requires immediate care or for immediate care of a chronic condition, as well as follow-up visits for an accidental bodily **injury** or **life-threatening medical emergency**.
- The plan pays benefits for **physician** and facility charges for treatment received at an urgent or emergency care center.



What If I Need To Be Admitted To The Hospital?

When you need to be admitted to the **hospital**, it can be a stressful time for you and your family. But, it is important to remember to ask your **physician** a few questions before you are admitted.



1. Why do I need to be treated in the **hospital**? Are there any treatment alternatives?
2. What procedures are you performing and what are the possible complications?
3. How long will I be in the **hospital**?
4. What is the expected recovery period following my discharge?
5. How will any pain I experience be controlled or managed?
6. Will I require follow-up care with you or another **physician** after I am discharged?
7. What is my prognosis and what changes do I need to make?
8. Is the facility in my network?
9. Have you called to verify the benefits available through my health plan?

What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- **Inpatient** room and board charges, up to the **hospital's** semi-private room rate. Charges made by a **hospital** having only single or private rooms will be considered at the least expensive rate for a single or private room.
- **Inpatient** room and board charges for specialty care units (ICU, CCU, Burn Unit, etc.).
- Consultations provided by a **physician** during your confinement.
- **Physicians'** visits, up to one visit per day, per **diagnosis** (unless visits are by different **physicians** and for different **diagnoses**).
- Charges of a skin bank, bone bank or other tissue storage bank.
- Certain services, supplies and treatment provided in the **hospital** during your confinement, including, but not limited to:
 - use of operating, delivery, recovery and treatment rooms;
 - laboratory and x-ray services and interpretation of the results;
 - anesthesia and its administration;
 - use of incubators, oxygen and kidney machines;
 - **physical therapy**, occupational therapy, and speech therapy;
 - chemotherapy and radiation therapy;
 - respiratory therapy;
 - drugs and medicines consumed on the premises; and
 - dressings, supplies and casts.

What If I Need Skilled Nursing Or Rehabilitative Care?

After an **inpatient** stay or after **surgery** it may be appropriate to complete your recovery in a facility that specializes in providing restorative and rehabilitative care, rather than acute care. To receive this care, you may be admitted to another facility or transferred to another floor or wing of the same facility. In other cases, treatment may be able to be provided in your home. Charges will be covered as described below and will be payable as described in the section titled "Overview of Benefits."

Skilled Nursing Or Rehabilitative Care

Services of a facility licensed as a rehabilitation facility can benefit patients with a range of medical needs, from long-term 24-hour nursing care to short-term rehabilitation. A broad range of services are available to address the patient's advanced medical, social and personal care needs.

What Is Covered?

Services will only be covered if the admission begins within 14 days after the end of a covered period of **hospital confinement** and the confinement in the skilled nursing or rehabilitation facility is for the same or a related cause as that prior covered **hospital confinement**.

This plan will cover the level of care appropriate for your condition. Skilled nursing and rehabilitative care benefits include:

- Room and board, not to exceed the most common semiprivate room rate of the **hospital** from which the **covered individual** was discharged.
- Other **inpatient hospital** services even though rendered by a skilled nursing or rehabilitation facility.
- **Physical therapy**.
- Speech therapy where speech is lost due to **illness** or **injury**.
- Occupational therapy to restore function lost due to **illness** or **injury**.
- Follow up care provided by the skilled nursing or rehabilitation facility for a covered service rendered while you were confined in the **hospital**.
- All **prescription drugs** dispensed by a skilled nursing or rehabilitation facility.
- **Physician's** visits in a skilled nursing or rehabilitation facility.

Home Health Care

Home health care services can often offer patients increased levels of comfort and security by allowing them to be treated by **health care professionals** in their own home environment rather than in a **hospital**. When those services meet the following criteria, this plan provides for services of a **home health care agency** that is **Medicare**-approved and licensed in the state in which it is located:

1. Services are under the direction of a **physician** who provides and regularly reviews a written treatment plan.
2. Services conform to the **physician's** written treatment plan outlining the patient's **diagnosis**, prognosis and medical needs or to avoid placing the patient at risk for serious medical complications; and
3. Services are provided by a licensed **nurse**, therapist, or home health aide who is an employee of the **home health care agency**.
4. Services are intermittent or hourly in nature,
5. The services are provided in lieu of hospitalization,
6. The member is homebound because of **illness** or **injury** (i.e., the member leaves home only with considerable and taxing effort and absences from home are infrequent, or of short duration, or to receive medical care), and
7. The nursing services provided are not primarily for the comfort or convenience of the patient.

What Is Covered?

The following benefits are available through this plan to assist a patient requiring health services in his or her home:

- Part-time or intermittent nursing care by a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) under the supervision of an RN.
- Part-time or intermittent home health aide services (caring for the patient) by an aide.
- **Physical therapy** rendered by a **physical therapist** or a Physical Therapy Assistant (PTA).
- Occupational therapy rendered by an **occupational therapist** or Certified Occupational Therapy Assistant (COTA).
- Speech therapy.
- Services of a Master Social Worker (MSW).
- Infusion therapy, provided by a **home health care agency** or a licensed home infusion company.
- Other covered services billed by a **home health care agency**.
- **Physician** home visits.

Hospice Care

Facing the necessity of end of life care for yourself or a loved one is especially difficult. **Hospice** care services help to ensure that the dying person's last days are filled with comfort and dignity.

What Is Covered?

The following benefits are available through this plan to assist both the dying person and his or her caregiver:

- Room, board and other services and supplies for **inpatient hospice** care.
- **Outpatient hospice** charges.
- Part-time or intermittent nursing care of a Registered Nurse (RN), Licensed Practical Nurse (LPN) or Licensed Vocational Nurse (LVN) under the supervision of an RN.
- Occupational, physical or respiratory therapy.
- Part-time or intermittent home health aide services by an employee of the **hospice**.
- Services for pain control and acute and chronic symptom management by a **hospice**.
- Medical supplies prescribed by a **physician** and supplied by the **hospice**.
- Drugs and medicine supplied by the **hospice**.
- Consultation or case management by a **physician**.

What If I Need Rehabilitative Therapy?

A very important part of the treatment and recovery process may be some type of therapy. Therapy can help strengthen parts of the body that have lost function. In some cases therapy may be the only needed treatment for your condition. In other cases therapy may be part of a treatment program designed to assist with your recovery. You and your **physician** will decide what type of therapy is right for you.

Below are several questions you may want to ask your **physician** or therapist as you begin therapy.

1. What type of therapy am I receiving?
2. Why is this the right type of therapy for my condition?
3. How often will I need therapy?
4. How long will my treatment continue?
5. Where will the treatment be performed?
6. At what point will my progress be evaluated?
7. What type of activities will my therapy consist of?



What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Occupational therapy prescribed by a **physician** and necessary to improve, develop or restore physical functions lost or impaired due to **illness, injury** or a covered surgical procedure. Services must be rendered by a **physician, occupational therapist** or a Certified Occupational Therapy Assistant under the direction of a **physician** or an **occupational therapist**.
- **Physical therapy** prescribed by a **physician** and necessary to improve, develop or restore physical function lost due to **illness, injury** or a covered surgical procedure. Services must be rendered during a covered **hospital confinement**, in the **outpatient** department of a **hospital**, a free-standing **physical therapy** center, a **Medicare** approved rehabilitation facility or a **physician's** office. Services must be rendered by a **physician, physical therapist**, a Certified Physical Therapy Assistant under the direction of a **physician** or a **physical therapist**, or a Certified Athletic Trainer (ATC) under the direction of a **physician** or **physical therapist**.
- Speech therapy when prescribed by a **physician** and necessary to restore or improve a speech disorder that results from **illness, injury** or covered surgical procedure, or to treat speech delay where the delay is caused by an identified **illness, injury** or **birth defect**. Services must be rendered by a **physician, speech therapist** or a **speech therapist** assistant under the direction of a **physician** or a **speech therapist**.
- Phase 1 and Phase 2 cardiac rehabilitation for those patients with certain cardiac conditions who would materially benefit from cardiovascular exercise, and who are unable to engage in unsupervised exercise without a clear risk of an acute cardiac event. Cardiac rehabilitation should be initiated as soon after the cardiac event as it is safe to begin (depending on the condition, typically no more than 6-12 months after a **surgery** or procedure is performed). Services must be provided by a **Medicare** approved facility in accordance with **Medicare** guidelines.

What If I Am Going To Have A Baby?

Congratulations on the upcoming birth of your child! When you learn of your pregnancy, it is often a very emotional time for you and your loved ones. Once you get over the initial surprise, it is very important that you start making decisions about your pre-natal care and the **physicians** who will help you bring your child into this world.

Yes! You Can Help Improve The Health Of Your Pregnancy!

The first step toward improving the quality of your pregnancy and your baby's health is to seek good pre-natal care, which includes the following:

1. Good nutrition and healthy eating habits including a well-balanced diet.
2. Frequent pre-natal office visits with your **physician**.
3. Routine testing, including ultrasounds, blood screenings, and other necessary tests as determined by your **physician**.
4. Following the advice of your **physician**.
5. Calling your **physician** whenever you are experiencing a symptom that you think may be a danger sign.

The next step is choosing the right **physician** for you. It is important to ensure that the **physician** you select will provide pre-natal care, as well as delivery and post-natal services. And make sure that you find a **physician** who you feel comfortable with, so that you feel okay asking questions.

What Is Covered? - Mother's Expenses

This plan provides coverage for certain medical expenses associated with maternity care for the **employee**, spouse and/or **dependent** children, as well as their eligible babies. The following services are covered at the benefit levels shown in the section titled "Overview of Benefits":

- **Physician's** charges associated with pre-natal and post-natal care, including routine testing and ultrasounds, but excluding services related to complications. Those services are covered the same as **medically necessary**, non-pregnancy related services.
- Amniocentesis when **medically necessary** to determine the condition of the fetus.
- **Inpatient** covered **hospital** services related to your pregnancy and delivery.
- **Birth center** charges for **hospital** on-site centers.
- **Physician's** charges associated with delivery services (including **surgery** and related anesthesia).
- Surgical assistance provided by a **physician's** assistant or another **physician**, when **medically necessary** and ordered by the attending **physician**.
- Obstetrical services provided by a **physician**.
- Genetic testing when **medically necessary** to establish a **diagnosis** of an inheritable disease if the patient has clinical symptoms or is at direct risk of inheriting the disease and the results of genetic testing will directly impact the patient's treatment and all other means of determining a definitive **diagnosis** have been exhausted.

What Is Covered? - Newborn's Expenses

As long as you or your **covered spouse** enrolls your eligible newborn within 30 days following his or her birth, the plan pays benefits for the following services (even if the plan does not cover the mother's expenses). The following services are covered at the benefit levels shown in the section titled "Overview of Benefits":

- Your covered newborn's **inpatient** covered **hospital** services.
- Initial examination by a **physician** other than the delivering **physician**.
- Routine nursery visits (up to one visit each day for each **diagnosis**) during the newborn's **hospital** stay.
- Consultations provided by a specialist.
- **Physician's** charges associated with circumcision.



You Should Know

The provisions of this plan are intended to comply with a federal law prohibiting all group health plans from restricting the length of the **hospital** stay to less than 48 hours following vaginal delivery and less than 96 hours following a cesarean section. In addition, the plan does not require any prior authorization for **hospital** stays less than 48 hours (or 96 hours as applicable). After consulting with you, your attending **physician** can still elect to discharge you and/or your baby earlier than 48 hours (or 96 hours as applicable) following delivery.

DISEASE SPECIFIC TREATMENTS

Complex medical conditions require complex treatments to help patients manage their diseases. Though the treatments can be extremely difficult, often they can help patients live full, active lives. If you or a family member is facing the need for an invasive treatment, you are likely also coping with stress and anxiety, decisions about treatment options and the need for support.

What If I Need Chemotherapy?

Though cancer and its treatments come in many forms and varieties, chemotherapy, also known as cytotoxic therapy, is one of the more common ways to fight the disease.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Injectable chemicals and their administration.

IMPORTANT: Please refer to the section titled “What if I Need a Specialty Injectable Medication In My Physician’s Office?” for information regarding benefits applicable to chemotherapy medications not provided by a **hospital**.

What If I Need Dialysis?

Dialysis is the most common method to treat advanced and permanent kidney failure. During the waiting period for **Medicare** benefits, this plan provides benefits for dialysis due to chronic renal failure as described below and will be payable as described in the section titled “Overview of Benefits.”

What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Dialysis treatment performed in:
 - the **outpatient** department of a **hospital**,
 - a facility recognized by **Medicare** for dialysis, or
 - the patient’s home.

What If I Need To See A Physician?

There are many types of **physician** related services that are covered under the plan. Services may be for **inpatient** and/or **outpatient** treatment, including consultations and office visits.

Preparing For A Physician Visit

In most cases, your **physician** will see you for less than 10 minutes. To prepare and make the most of a **physician** visit, whether on an **inpatient** or **outpatient** basis, you may want to do the following:

- Write down your most important concerns –
 - Symptoms, including when they first occurred and how often they occur,
 - History of the problem, including whether you have had the problem before and how long ago,
 - Treatments you may have tried.
 - ♦ Bring records of information (medical records from other current or previous **physicians**, medications you currently take or have previously taken, including dosage information and over-the-counter medications, other health problems, etc.)
- Bring along a family member to help you with questions and/or any instructions your **physician** might give you.
- Take notes and ask questions or ask for further explanations regarding your health.
- Follow your **physician's** recommended treatment.



What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Office exams provided to treat an **illness** or **injury**.
- Charges by a retail establishment health clinic (“MinuteClinic”, “Take Care Health Clinic”, “RediClinic”, etc.) for exams to treat an **illness** or **injury**. Services through a retail establishment health clinic will be paid in the same manner as an office visit, payable at the **Regional PPO network** level and subject to an office visit co-pay. You must pay for the services rendered in full and then submit the paid receipt to the plan for reimbursement. You will be reimbursed the full amount, minus the office visit co-pay. Please note that this benefit is not eligible to be paid at the Port Huron and Affiliates benefit level at any time, regardless of the circumstances.
- Charges relating to chiropractic care (spinal and osteopathic manipulation), up to one treatment per day and limited to a calendar year maximum. The plan limits coverage to office visits, x-rays, manipulations, myotherapy and/or orthomolecular therapy, thermography, injections and **physical therapy** (subject to the plan’s chiropractic maximum).
 - These services may be rendered by a Doctor of Chiropractic (DC) or a Doctor of Osteopathy (DO).
- Charges associated with injections to treat an **illness** or **injury**, including antigens and serums. **For important information regarding injections of specialty injectable medications, please refer to the section titled “What If I Need A Specialty Injectable Medication In My Physician’s Office?”**
- Charges related to **outpatient mental disorders** and substance abuse treatment when rendered by a **physician, psychologist, psychiatrist**, limited licensed **psychologist**, Master Social Worker (MSW), or a chemical dependency counselor who is under the direction of a **psychiatrist** or **psychologist**.

What Is A Consultation?

A consultation is a meeting with a **physician**, or a meeting of two or more **physicians** to discuss the **diagnosis**, prognosis, and treatment of a particular case.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- Consultations, including those:
 - for medical conditions that require **surgery**;
 - for medical conditions that do not require **surgery**; and
 - provided by a **physician** (other than the attending **physician**) during a **hospital confinement**, or due to an emergency in the emergency room of a **hospital**.

What If I Need Surgery?

There are many reasons why someone may need to have **surgery**. Some **surgeries** are due to an emergency, but most **surgeries** today are elective. By having an elective **surgery**, you have time to learn more about your **surgery** and find out if it is the best treatment for you.

A surgical procedure may consist of a cutting operation, suturing of a wound, treatment of a fracture, relocation of a dislocation, radiotherapy (if used in lieu of a cutting operation), diagnostic and therapeutic endoscopic procedures or laser **surgery**. Also certain injections are also classified as **surgery**. The plan will cover charges related to a surgical procedure as described below, including charges for blood that has not been replaced by donation and charges for you to store your blood for **surgery** at a later time.

Preparing For Surgery

Prior to your elective **surgery**, there are many questions you can ask your **physician**:

1. Why do I need to have **surgery** and what will happen if I do not have **surgery**?
2. Are there any alternatives?
3. Are there any risks or side effects associated with the surgical procedure?
4. How long will it take for me to recover?
5. Should I get a second surgical opinion?
6. What do I need to do to prepare for **surgery**?



What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- **Inpatient** or **outpatient surgery** performed in a **hospital, ambulatory surgical center, urgent care facility** or **physician’s** office, including:
 - facility charges;
 - surgeon’s charges;
 - surgical assistance provided by a **physician** assistant or another **physician** for surgical procedures that need an assistant; and
 - related anesthesia when administered by a **physician** (other than the operating or assisting **physician**) or a Certified Registered Nurse Anesthetist (CRNA).
- Diagnostic surgical procedures.
- Placement or replacement of functional implants (e.g., pacemaker, defibrillator, insulin pump, artificial limb) or non-functional implants (e.g., breast implant).
- The removal of sutures provided the plan covers the initial placement of the suture, and the suture is removed by a **physician** other than the **physician** who initially placed it.

- Acupuncture or acupressure, when administered by a **physician**, and used as an anesthetic in connection with a covered **surgery**.
- Sterilization, including tubal ligations or vasectomies.
- Oral surgical procedures and other related services, when performed by a **physician** (MD or DO), Doctor of Dental Surgery (DDS), or Doctor of Dental Medicine (DMD), limited to:
 - one pre-surgical examination or consultation;
 - removal of a tumor;
 - incision and drainage of an abscess and related anesthesia;
 - removal of non-odontogenic cysts and related anesthesia;
 - repair of damaged oral tissues due to an accidental bodily **injury**;
 - resection of a non-odontogenic tumor of soft tissue and related anesthesia;
 - sialolithotomy;
 - closure of salivary fistula; and
 - extraction of impacted teeth.
- Surgical procedures related to covered hearing or vision services, including:
 - **physician's** charges related to **surgery**; and
 - related anesthesia and facility charges.
- Repair of jaw or natural teeth because of an accidental bodily **injury** within 12 months of the accident, unless the healing process delays treatment.

Second Surgical Opinions

The plan does not require that you obtain a second surgical opinion for an **inpatient** or **outpatient surgery**. However, getting a second surgical opinion from another **physician** is a good way to ensure that your **surgery** is **medically necessary** and the appropriate **surgery** for you. Your **physician** may refer you to another **physician** for a second opinion or you can coordinate a second opinion from any **physician** of your choice.

Women's Health And Cancer Rights Act

After a **medically necessary** mastectomy, the plan will provide coverage in the same manner as any other covered surgical procedure. If a mastectomy is performed, the plan will provide coverage for reconstruction of the breast on which the mastectomy was performed. It will also cover reconstruction of the other breast to produce a symmetrical appearance. The plan will also provide coverage for breast prosthesis due to a mastectomy.

What If I Need Anesthesia?

The plan pays for anesthesia associated with a covered surgical procedure. Your **physician** will inform you whether or not your surgical procedure requires anesthesia. There are three types of anesthesia that your **physician** may choose:

- Local anesthesia is injected in tissue and numbs a small portion of your body and only for a short period of time. This type of anesthesia is generally reserved for **outpatient** procedures and skin and soft tissue **surgery**, in which a small incision and no deep penetration occur. Charges for this type of anesthesia are included in the surgeon's bill and no additional billing would be payable.
- Regional anesthesia is injected into a cluster of nerves and numbs a larger portion of your body (e.g., arm, leg or the lower portion of your body) for a few hours. During the time you are under this type of anesthesia, you may be awake and given a sedative.
- General anesthesia is administered intravenously or by inhalation. With this type of **surgery** you are not conscious during **surgery**.

When you decide to have **surgery**, ask to meet with the anesthesiologist (**physician** or a Certified Registered Nurse Anesthetist (CRNA)) who will be administering the anesthesia. When meeting with the anesthesiologist, you may want to ask the following questions:

1. How long will I be under anesthesia?
2. What are the side effects of having anesthesia?
3. I am taking prescribed medications, vitamins and/or supplements, does this pose any risk?
4. Are there specific risks for someone my weight, height and age?
5. Is any special consideration taken if I am a smoker?

Weight Management – Only Covered for Individuals Enrolled in the Comprehensive Plus Plan

Expenses related to weight management for Adjustable Gastric Banding (AGB) for the treatment of obesity will not be covered except as described below. Surgical procedures for the purpose of weight reduction will be considered only if the **employee** has been in a benefit eligible position for a minimum of three continuous years immediately preceding the **surgery** and the patient has had coverage under the plan for a minimum of two continuous years immediately preceding the **surgery**.

All expenses relating to weight management are limited to one course of treatment per lifetime.

For the purpose of determining these benefits, the plan will base the determination of morbid obesity on the patient's Body Mass Index (BMI) or overweight status. A BMI greater than 40, or more than 80 pounds overweight for a female or more than 100 pounds overweight for a male will be considered indicative of morbid obesity. A BMI greater than 35 but less than 40 will also be considered indicative of morbid obesity where the patient has one or more of the following co-morbid conditions that are either life threatening or which will significantly impair a major life function (e.g., mobility, ability to work, ability to self care); severe sleep apnea, Pickwickian Syndrome, congestive heart failure, cardiomyopathy, Insulin dependent diabetes, severe musculoskeletal dysfunction.

The plan will review patient history for optimal candidacy for any proposed surgical treatment according to current, generally accepted medical practices. This review will consider whether the patient has been unable to lose weight through non surgical, conventional measures and whether the individual's ability to manage the surgical intervention and required post operative care has been assessed through a psychological evaluation. Unsuccessful weight loss attempts and lifestyle changes should be documented and medically or professionally supervised for 12 consecutive months. The **surgery** must be completed within 24 months following the documentation period as stated. (* Defined for the weight management section, for the purpose of medically or professionally supervised, to receive treatment from A qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO), or a Nationally recognized weight loss program.) Other limitations include:

1. Appendectomies and cholecystectomies in conjunction with surgical treatment of morbid obesity will be considered incidental and not covered unless the individual has an existing condition that requires the additional surgical treatment.
2. Panniculectomy (**surgery** to remove loose skin) resulting from weight loss will be covered only if it is **medically necessary** along with the results of documented history of treatment by a **physician** for related **illnesses** for a minimum of six months where the treated condition is no longer controlled through any other means.

What Is Covered?

- Office visits.
- Clinic visits.
- X-ray and laboratory.
- **Surgery.**
- Anesthesia.
- Follow-up.

What Is Not Covered?

- Complications to the procedure due to non-compliance.
- Health clubs.
- Weight machines.
- Nutritional evaluation assessments.
- Psychological evaluations (for weight management).
- Reversals (except for complications as a direct result of **surgery**).

What If I Need A Transplant?

When you or your family member are preparing to undergo transplantation, it can cause great emotional and physical strain. It may help to know that doing some research and learning what to expect and how to prepare will help you ensure that the procedure is a success.

Preparing For A Transplant

Being prepared means taking a few extra steps prior to the time of **surgery**. The following list is intended to help guide you through this often overwhelming process.

1. Stay Positive – Good emotional health will help increase your body's health. Be sure to talk to your **physician** about stress and anxiety management, and find out what types of services may best help you manage your health.
2. Get Educated – Ask lots of questions! Your **physician** and transplant team will be able to provide you with information to help you understand the procedure and its risks, as well as what to expect once the procedure is completed.
3. Get Support – Family and friends are a crucial lifeline for many transplant patients. However, there are also support groups that are intended to help you manage the numerous emotions that are common to transplant patients. Again, your **physician** and transplant team will be able to assist you with locating support groups in your area.
4. Get Financially Ready – Talk to your **physician** and the team at the transplant center regarding the procedures that will be performed as well as the expected reimbursement through your medical plan. Also, be sure to ask about the transplant network and how you can maximize your benefits by utilizing its resources.

Your Transplant Network

The **Corporation** has contracted with OptumHealth to be your transplant network. OptumHealth is an independent contractor and provides centers of excellence for specific types of transplant procedures. Services rendered by an OptumHealth provider are payable at the **Port Huron Hospital** and Affiliates level.

The centers of excellence found in the OptumHealth network have been specifically screened based on the high quality of services provided and the higher than normal successful outcome rates these facilities have experienced. By utilizing facilities with a history of successful outcomes, the likelihood of a successful outcome increases for you or your covered **dependent**.

Whenever you or your covered family member chooses an OptumHealth provider, you may experience a savings. The savings is created because Network services are provided at a discount, resulting in a lower copayment for you.

While this plan has arranged these discounts when an OptumHealth provider is utilized, it is important to remember that you may be treated wherever you and your **physician** deem appropriate. You, together with your transplant team, are ultimately responsible for determining the appropriate treatment regardless of coverage by this plan.

What Is Covered?

The following services are covered at the benefit levels shown in the section titled “Overview of Benefits”:

- **Physician’s** charges related to the **surgery**, including charges for a surgical **physician’s** assistant and related anesthesia.
- **Inpatient** covered **hospital** services related to the transplant procedure.
- Harvesting, storage and transportation costs related to the donated organ.
- When you or your covered family member is the recipient of a donated organ, this plan will also cover the donor’s medical expenses incurred as the result of the transplant, provided that the expense is charged to the **covered individual** and no other source is available to pay the actual donor’s medical expenses.
- Expenses of a **covered individual** who donates an organ.
- Storage of the patient’s own blood in advance of an approved transplant surgical procedure.
- Travel and lodging expenses incurred during the pre- and post-transplant phases (immediately prior to and after the transplant) will be reimbursed up to \$40 per day, up to a total of \$10,000, for a **covered individual** when the transplant network is utilized.

What Is Not Covered?

These exclusions will apply only to transplant expenses. Please see the “What is Not Covered?” section for all other plan exclusions.

- Fees charged by blood and organ donors.
- Charges for a donor search.
- Expenses incurred while waiting for a human organ transplant (e.g., housing, transportation, living expenses, etc.), unless the transplant network is utilized.
- The transplant of non-human or mechanical organs.
- A donor’s medical expenses incurred because of the transplant when the recipient is a **covered individual** but does not incur a charge for the expense.
- Any charge for the organ itself.
- Transplant procedures which are considered **experimental**.

What If I Need A Prescription Medication?

Understanding the importance your medication plays in your treatment will help you get the greatest benefit from your prescription. It is important to take an active role in your health care by working with your **physician**, **nurse**, and pharmacist to learn as much as possible about your prescription.



Four Ways To Make Your Medications Work For You

1. Give Your Health Care Team Important Information

- Be a partner with your health care team. Tell them about:
 - All the medicines, vitamins, herbals, and dietary supplements you are already taking, including prescription medications, vitamins, dietary supplements and over the counter medications.
 - Any allergies or if you have had problems when taking a medicine before.
 - Any other **illness** or medical condition you have, like diabetes or high blood pressure or if you are pregnant, considering becoming pregnant or nursing a baby.
 - Any concerns you might have with the cost of the medication. There may be another medicine that costs less and will work similarly.

2. Get The Facts About Your Medicine

- **Be Informed**
 - Ask questions about every new prescription medicine.
- **Read The Prescription**
 - If your **physician** writes your prescription by hand, make sure you can read it. If your **physician** submits your prescription to the pharmacy electronically, ask for a copy of the prescription.
- **Know What Your Medicine Is For**
 - Ask your **physician** to write down on the prescription what the medicine is used for...not just "take once a day" but "take once a day for high blood pressure."
- **Ask Questions**
 - If you have other questions or concerns:
 - Talk to your **physician** or pharmacist.
 - Write questions down ahead of time and bring them to your appointment.

3. Stay With Your Treatment Plan

Now that you have the right medicine, you will want to carry out the treatment plan. But that is not always easy. The medicines may cause side effects. Or you may feel better and want to stop before finishing your medicines.

- **Take all the antibiotics you were prescribed.** If you are taking an antibiotic to fight an infection, it is very important to take all of your medicine for as many days as your **physician** prescribed, even if you feel better.
- **Ask your physician if your prescription needs to be refilled.** If you are taking medicine for high blood pressure or to lower your cholesterol, you may be using your medicine for a long time. If you run out of refills, it may be time to see your **physician**.
- **Tell your physician about any side effects.** You may be able to take a different amount or type of medicine.
- **Never give your prescription medicine to somebody else** or take prescription medicine that was not prescribed for you, even if you have the same medical condition.
- **Ask whether you need** blood tests, x-rays, or other lab tests to find out if the medicine is working.

4. Keep A Record Of Your Medicines

- **Keep track of what medications you are taking.** Make sure that your list includes information about the name of the medication, the dosage and how long you have been taking the medication.
- **Include non-prescription medications.** Many people take a vitamin or a dietary supplement or some other type of non-prescription medication. Sometimes these can interact with your prescription medications. Make sure your list of medications includes both the prescription and non-prescription medications you are taking.
- **Keep the list up to date.** If you begin taking a new medication – or stop taking a medication – be sure to revise your list. Also, make revisions if your dosage changes.
- **Put the list in a safe place.** Make sure you will be able to find it in an emergency. Tell your family members and friends where they can find your list.
- **Take the list with you to your physician appointments, hospital and visits to the emergency room or urgent care center.** The **physicians** and **nurses** at these facilities will need to know what medications you have been taking. This will assist them in providing the best possible treatment.

Purchasing Decisions About Prescription Medications

- **In a medical facility**

- In some cases you or your **dependent** may receive prescription medications in your **physician's** office, from a **hospital** on an **inpatient** or **outpatient** basis, from a surgical center, through a **home health care agency** or through **hospice** or for dialysis or chemotherapy. In these situations your medications will be covered as described in the respective section of this **SPD**. The charges from these facilities will be subject to, when applicable, the plan's **deductible**, any applicable plan maximums and any applicable exclusions. You may wish to ask your **physician** if the medication can be obtained through the pharmacy as it is likely that those medications received from the pharmacy will receive a greater discount.

- **In any Port Huron Hospital Pharmacy**

- **Prescription drugs** purchased in any Port Huron Hospital pharmacy are covered by the **prescription drug** benefit administered by Pharmacy Data Management, Inc. When you purchase covered drugs from any Port Huron Hospital pharmacy, present your prescription order and identification card to the pharmacist. (Prescription orders which the pharmacy received by phone from your **physician** or **dentist** may also be covered.) Each new or refilled **prescription drug** will be payable as described in the section titled "Overview of Benefits." Your **prescription drug** expenses will not be applied to your **deductible** or **out-of-pocket maximum** expense limits, but will apply toward your lifetime maximum.

- **In a pharmacy other than a Port Huron Hospital Pharmacy**

- Pharmacy Data Management, Inc. (PDMI) has a network arrangement with most pharmacies. If you utilize a pharmacy that has an arrangement with PDMI for a 30-day supply, each new or refilled **prescription drug** will be payable as described in the section titled "Overview of Benefits." Your **prescription drug** expenses will not be applied to your **deductible** or **out-of-pocket maximum** expense limits, but will apply toward your lifetime maximum.
- When covered drugs are purchased from a pharmacy that does not have an arrangement with PDMI, you will be required to pay the full charge made by the pharmacy for the prescription. For a 30-day supply, you may submit a completed **prescription drug** claim form to Pharmacy Data Management, Inc. for reimbursement. Each new or refilled **prescription drug** will be payable as described in the section titled "Overview of Benefits." Your **prescription drug** expenses will not be applied to your **deductible** or **out-of-pocket maximum** expense limits, but will apply toward your lifetime maximum.

Please remember that the **prescription drug** benefit does not cover a 90-day supply of any medication purchased at a pharmacy other than a Port Huron Hospital pharmacy.

- **In a pharmacy outside of the United States of America**

- When you utilize a pharmacy outside of the United States, claims must be submitted directly to Port Huron Hospital Human Resources.

Please note that this plan's prescription coverage is intended to be the primary coverage for you and certain **dependents** as described in the section titled "Coordination of Benefits (COB)". Should you have other coverage available to you or your **dependents**, and if that coverage is the primary coverage for the patient, this plan will neither cover any prescription expenses on a secondary basis nor reimburse any other source for charges incurred for your or your **dependents'** prescriptions.

IMPORTANT: Please note that specialty injectable and infusible medications must be filled through the PrecisionRx Specialty Solutions Program. Specific information regarding this program and the benefits payable under this program can be found immediately following this section.

What Is Covered?

- Covered drugs are those, which under Federal Law, are required to bear the legend: "Caution -Federal Law prohibits dispensing without a prescription." Injectable insulin, which may not require a prescription, is also a covered drug.
- Diabetic syringes and needles, limited to Port Huron Hospital Pharmacy Place only.

What Is Not Covered?

BELOW ARE MEDICATIONS THAT ARE NOT COVERED WHEN OBTAINED THROUGH A PHARMACY (PARTICIPATING OR NON-NETWORK) OR THROUGH THE PRECISION Rx SPECIALTY SOLUTIONS PROGRAM.

- All contraceptive medications (oral or otherwise).
- All contraceptive devices.
- Hypodermic needles and syringes (except as provided under "What Is Covered?").
- Support garments.
- Over-the-counter-items, except insulin.
- Stock restricted drugs which are not also federally restricted.
- Drugs which cost less than the applicable copayment.
- **Experimental or investigational** drugs.
- Medication for which you do not legally have to pay, or which is covered under Workers Compensation or any other State or Governmental Agency.
- Medication furnished by any other drug or medical service at no charge to you.
- Non-medical substances, regardless of their intended use.
- Drugs used to treat an **illness, injury** or treatment not covered by the medical plan.
- **Prescription drugs** taken beyond or as an exception to the manufacturer's recommendation for limited usefulness, (i.e., Anorexiant, smoking cessation products, etc.)
- Viagra and/or any drug used to treat erectile dysfunction.
- Drugs that are not considered a maintenance drug for the individual for whom the drugs or medications are being dispensed.
- Medication not sold or dispensed in a pharmacy.

What If I Need A Specialty Injectable Or Infusible Medication In My Physician's Office?

The PrecisionRx Specialty Solutions Program must be used for certain medications related to the conditions or treatment programs listed below. You can fill your prescriptions up to two times and automatically receive the highest level of benefits. However, after your first two prescription fills, you must transition to the PrecisionRx Specialty Solutions Program in order to keep receiving the highest level of benefits.

Keep in mind that medications obtained through PrecisionRx receive a substantial discount, and are covered at a higher benefit level. This may reduce your cost.

To receive these specialty drugs, simply provide a copy of your identification card to your **physician**. Your **physician** will submit the prescription.

	COMPREHENSIVE PLUS PLAN			COMPREHENSIVE PLAN		
	Port Huron Hospital Affiliates (This benefit does not apply to services rendered at Port Huron Hospital)	Network	Non-Network	Port Huron Hospital Affiliates (This benefit does not apply to services rendered at Port Huron Hospital)	Network	Non-Network
Benefit Payment for Specialty Injectable or Infusible Medications Obtained Through Precision Rx:	90% after deductible	90% after Port Huron Hospital and Affiliates deductible	90% after Port Huron Hospital and Affiliates deductible	80% after deductible	80% after Port Huron Hospital and Affiliates deductible	80% after Port Huron Hospital and Affiliates deductible
Benefit Payment for Specialty Injectable or Infusible Medications That Are <u>Not</u> Obtained Through Precision Rx and <u>Are Not Available</u> Through Precision Rx:	90% after deductible	80% after deductible	70% after deductible	80% after deductible	70% after deductible	60% after deductible
Benefit Payment for Specialty Injectable or Infusible Medications That Are <u>Not</u> Obtained Through Precision Rx but Medications <u>Are Available</u> Through Precision Rx:	70% after Non-Network deductible	70% after Non-Network deductible	70% after deductible	60% after Non-Network deductible	60% after Non-Network deductible	60% after deductible

Specialty injectable and infusible medications to treat the following conditions can be obtained:

Asthma	Neurology
Chronic Renal	Oncology
Crohn's Disease	Oncology Adjunct
Endocrinology	Ophthalmology
Fabry's Disease	Osteoarthritis/Rheumatoid Arthritis
Pain Management	Gaucher's Disease Parkinson's
Growth Hormone	Psoriasis
Hematology/Cardiology	Pulmonary
Hemophilia	Pulmonary Fibrosis
Hepatitis	Pulmonary Hypertension
Immune Therapy	Rabies
IVIG	Other Disorders
Multiple Sclerosis	

Certain medications are not covered through the PrecisionRx Specialty Solutions Program, and a complete list can be found under "What Is Not Covered?" in the section titled "What If I Need a Prescription Medication?".



SUPPLEMENTARY SERVICES AND SUPPLIES

The best course of treatment for you may not include hospitalization, diagnostic testing, or other services previously described. Rather, your condition may require specialized care or supplies in conjunction with the services being provided by your **physician**. These benefits supplement other coverage described throughout this document to complete the comprehensive program offered by your employer.

Medical Equipment, Medical Supplies, Orthotics And Prosthetics

This plan pays benefits for medical equipment and supplies that you and your family members may need to assist you with an **illness, injury, or congenital defect**.

What Is Covered?

Charges will be covered as described below and will be payable as described in the section titled "Overview of Benefits":

- Rental or purchase of medical equipment.
- Home uterine monitoring devices when the device replaces the need for **hospital confinement**, the **physician** confirms the pregnancy is high risk, and the monitor is FDA-approved.
- Medical supplies that are needed to help you manage your condition, including, but not limited to: jobst hose, colostomy supplies, crutches, canes, non-diabetes related syringes and needles, test strips, lancets, etc.
- **Orthotic** appliances such as braces and orthopedic shoes which are an integral part of a covered brace.
- Temporary and long-term prostheses.
- **Prosthetic devices**, as well as their replacement as needed due to the patient's growth or physiological change, or medical condition.
- Artificial devices that are non-functional are covered by this plan when required following **medically necessary** surgical procedures or loss due to **injury**.
- Replacement of an artificial limb when no longer functional.
- Necessary repairs or fitting adjustments to covered **orthotic** appliances and **prosthetic devices**.
- Initial breast prosthesis following a mastectomy.
- Replacement of breast prosthesis when due to change in patient's physical condition.
- One specially designed bra for breast prosthesis.



- Replacement of breast prosthesis when due to wear, tear or loss, limited to one in a two year period.
- Therapeutic shoes and shoe inserts for diabetics which are fitted and furnished by a **physician**, or prescribed by a **physician** and fitted and furnished by a medical equipment supplier. The benefit will be limited to one each per calendar year, unless additional are needed due to the patient's growth, physiological change or medical condition. In addition, your **physician** must certify that you have at least one of the following conditions:
 - Peripheral neuropathy with evidence of callus formation;
 - History of pre-ulcerative calluses;
 - History of previous ulceration;
 - Foot deformity;
 - Previous amputation of the foot or part of the foot; or
 - Poor circulation.

WHAT IS NOT COVERED?

While the plan provides a thorough and comprehensive level of coverage for you and your covered **dependents**, not every service is covered. The following is a list of services which are not covered by any portion of the plan.

1. **Abortion.** Charges related to an abortion, except when due to rape or incest, when the life of the mother would be endangered if the pregnancy were carried to term, or when therapeutic as determined by genetic counseling.
2. **Acupuncture and Acupressure.** Acupuncture or acupressure, except in connection with a covered surgical procedure.
3. **Ambulance.** The plan does **not** pay benefits for anything other than professional ambulance transportation charges, such as:
 - travel charges for regularly scheduled plane or train transportation,
 - transportation for the convenience of the patient,
 - transportation by other than a professional ambulance service, except as otherwise provided, and
 - transportation for a procedure or service that is not covered by the plan.
4. **Amniocentesis.** Amniocentesis to determine the gender of the newborn or in the absence of known risk factors including but not limited to, maternal age, previous child with chromosomal disorder, abnormal ultrasound, or family history or other documented risk of a detectable, single gene disorder.
5. **Anesthesia Separate Charges.** Charges billed separately by an anesthesiologist and a CRNA that, when the bills are combined, exceed **reasonable and customary**.
6. **Appliances.** This plan does not pay benefit for **dental** guards, dentures, orthodontic braces, hearing aids, arch supports, corrective shoes, and similar appliances, except as otherwise provided.
7. **Behavioral Modification Programs.** Charges related to behavioral modification programs, including behavioral testing.
8. **Biofeedback.** Charges related to biofeedback training.
9. **Chiropractic Care.** Chiropractic care when provided by a Doctor of Chiropractic (DC) or Doctor of Osteopathy (DO) - other than office visits, x-rays, manipulations, myotherapy and/or orthomolecular therapy, thermography, injections and **physical therapy** (subject to the plan's chiropractic maximum).
10. **Claim Forms.** Charges incurred for completion of claim forms.
11. **Claims Filing Deadline.** Claims filed later than the end of the year following the year in which the charge was incurred.
12. **Complimentary and/or Alternative Medicine.** Charges for services or supplies that are considered complimentary and/or alternative medicine, except as otherwise provided.

13. **Confinements, Consultations or Any Other Treatment or Service Provided in Connection With Not Covered Procedures.** Any **hospital** or other facility charges for procedures or confinements that the plan does not cover.
14. **Confinements for Testing/Physical Therapy.** Confinements solely for diagnostic testing, x-rays, physical checkups, **physical therapy**, and rest cures except when due to a **concurrent hazardous medical condition**.
15. **Contraceptive Fitting.** **Physician's** charges associated with the fitting of a contraceptive pessary or diaphragm.
16. **Contraceptives.** Implants, supplies, drugs, devices, and treatment for contraceptive purposes.
17. **Convenience Items.** Convenience items such as telephones, televisions, guest meals, guest beds, haircuts, manicures, etc.
18. **Coordination of Benefits.** Services rendered which are eligible for payment or coverage by any other plan that does not provide coordination of benefits.
19. **Cosmetic Procedures.** Cosmetic procedures unless necessary:
 - to improve the function of a part of the body, or
 - as the result of an **injury**, or
 - due to post- mastectomy breast reconstruction, or
 - to treat a **congenital defect**, or
 - for scar revision as a result of **illness** or **injury**.
20. **Custodial Care.** Charges/confinements for **custodial care** (services which primarily help an individual perform daily living activities).
21. **Days of Confinement.** This plan does not pay benefits for days of **hospital confinement** prior to the day of your elective **surgery**, unless required due to a **concurrent hazardous medical condition**.
22. **Days on Leave.** Charges for days when you or your covered **dependents** are not confined in the **hospital** (days when the patient is on leave from the **hospital**).
23. **Dental.** **Dental** expenses for the following:
 - **hospital confinements** or **hospital outpatient** expenses during which only **dental** services or oral surgical procedures are performed, unless necessary due to a **concurrent hazardous medical condition**, a medical need to utilize the facility or the age of the patient.
 - charges related to **dental** services, procedures, prosthesis, or implants except as specifically provided.
 - **dental** x-rays, except when performed in connection with a covered oral surgical procedure.
24. **Dialysis.** Charges for training of the patient and any individual who will be assisting him/her in operating the equipment, electricity or water used in operating the dialyzer, transfer of the dialyzer to another location of the patient's home, or installation of electric power, a water supply or a sanitary waste disposal system in conjunction with installing the dialysis equipment.

25. **Dietary Supplements.** Charges for oral dietary supplements that contain a dietary ingredient intended to supplement the diet.
26. **Duplicate Tests.** Duplicate tests by different **physicians**.
27. **Earwax Removal.** Charges for earwax removal, unless **medically necessary**.
28. **Educational and Self-Help Training/Testing.** Educational and self-help testing and training, except Port Huron Hospital's Diabetic Education Program.
29. **Environmental Control Equipment.** This plan does not pay benefits for equipment such as air conditioners, air filters, humidifiers, vaporizers, etc.
30. **Errors in Refraction.** Testing to determine errors in refraction, unless due to an **injury** or following a covered **surgery**.
31. **Eyeglasses and Contact Lenses.** Charges for eyeglasses and contact lenses.
32. **Experimental/Investigational.** **Experimental** or **investigational** care, treatment, services, supplies or drugs.
33. **Failure to Comply with another Plan.** Charges that are not payable by the primary plan covering the patient solely due to the patient's failure to comply with that plan's requirements for cost containment provisions (including – but not limited to - failure to pre-certify).
34. **Failure to Comply with this Plan.** Charges that may otherwise be payable when you or your provider fail to comply with this plan's request for information.
35. **Family Providers.** Services, care and treatment rendered by you, your spouse, or you or your spouse's mother, father, grandmother, grandfather, in-laws, brother, sister, half-brother or half-sister, son, daughter, stepchildren, aunt, uncle, cousin, niece, nephew, grandson, granddaughter, or anyone who resides with you or your spouse.
36. **Infertility Treatment.** Treatment, services, counseling or any procedure to correct **infertility** or to bring about or enhance the probability of conception.
37. **Fetal Surgery.** Charges related to fetal **surgery**.
38. **Foot Care.** Charges for foot care, including treatment (other than **surgery**) of corns, bunions, toenails, calluses, flat feet, fallen arches, weak feet and chronic foot strain, except removing nail matrix and diseased nail (i.e., infection) or care prescribed by a **physician** treating metabolic or peripheral vascular disease.
39. **Government/Military Hospital.** Services provided in a **hospital** operated by the U.S. government (or an agency of the government, such as a V.A. or military **hospital**) for an armed-services-related medical condition.
40. **Governmental/State.** Charges for which coverage is provided through, any federal, state, municipal or other governmental body or agency.
41. **Growth Hormones.**
42. **Hair Analysis.** Charges for hair analysis.

43. **Health Club Membership.** Membership costs included, but not limited to health clubs and weight loss programs, unless covered under Weight Management.
44. **Hearing.** Charges for hearing aids, devices, implants (except cochlear implants), routine hearing tests, any treatment received for degenerative hearing loss, and surgical correction of hearing loss unless due to **congenital defect**, disease or **injury**.
45. **Home Testing.** Charges for home testing kits.
46. **Homemaker Services.** Charges for homemaker or housekeeping services.
47. **Homeopathic Care.** Herbal medicines, holistic or homeopathic care, including drugs.
48. **Hospice.** Charges related to **hospice** care are covered, except for charges for respite care, bereavement counseling, funeral arrangements, pastoral counseling, financial/legal counseling and sitter or companion services.
49. **Hypnotherapy.** This plan does not pay benefits for hypnotherapy.
50. **Illegal Activity.** Charges incurred as a result of committing, or attempting to commit any illegal or criminal activity, unless the **illness** or **injury** is a result of a physical or mental condition.
51. **In-Vitro.** Artificial insemination, in-vitro fertilization and embryo transfer.
52. **Incomplete Claims Submission.** Charges when there has been an incomplete claim submission.
53. **Late Discharge.** Charges for "late discharge" or "late check-out" if the discharge results from convenience.
54. **Learning Disabilities.** This plan does not provide benefits for the treatment of **learning disabilities**.
55. **Legal Expenses.** Charges for legal expenses or fees incurred in obtaining medical treatment or payment of claims.
56. **Marital Counseling.** Charges for marital counseling.
57. **Massage Therapy.** Charges for massage therapy, except as otherwise provided.
58. **Medical Equipment.** Charges for rental of durable medical equipment that exceed the purchase price.
59. **Medically Necessary.** Services and supplies that are not **medically necessary**.
60. **Medical Supplies.** Charges for exercise equipment, blood pressure kits, diet scales, more than one specially designed bra for a breast prosthesis, etc., as well as charges for items that are not generally useful in the absence of **illness**.
61. **Megavitamin Therapy.**
62. **Myofunctional Therapy.** Charges for muscle training or training to correct or control harmful habits.

63. **Not Required to Pay.** Charges that you would not be required to pay if you did not have group health coverage.
64. **Nutritional Counseling.** Charges for nutritional counseling, except as part of a diabetes education program.
65. **Observation Care.** Charges for 23-hour **outpatient observation** care in excess of the cost of one day care at the **hospital's** semiprivate room rate.
66. **Off-Label Drug Use.** Charges for the use of an FDA-approved Drug for a purpose other than that for which it is approved, unless the drug is appropriate and generally accepted for the condition being treated based on **reliable scientific evidence**.
67. **Office Visits and Other Expenses for Marriage, Employment, Licensing or Regulatory Purpose.** Office visit charges for pre-employment, premarital, or any examinations required by licensing, regulatory, or other such purpose.
68. **Paternity.** Charges for paternity testing.
69. **Phone/Internet Conversations.** Charges for medical treatments, consultations or visits that consist of a telephone or internet conversation or other electronic communication.
70. **Plan Maximums.** Charges in excess of plan maximums, including preventive care and well baby care maximums.
71. **Pre-Existing Condition.** Expenses relating to a **pre-existing condition** (Refer to the paragraph titled "Does the Plan Have a Pre-Existing Condition Limitation?" in the section titled "Participating in the Plan" for further information).
72. **Primal Therapy.**
73. **Private Duty Nursing.**
74. **Providers Not Covered.** Services rendered by a provider who is not specifically included in the definition of a **physician** or specifically listed as a covered provider. This also applies to **inpatient** services rendered by a facility that is not defined as a **hospital**.
75. **Psychodrama.**
76. **Reasonable and Customary.** Charges in excess of those considered **reasonable and customary**.
77. **Recreational, Music, and Remedial Reading Therapy.** Charges associated with recreational, music and remedial reading therapy, except recreational therapy provided on an **inpatient** basis or as part of intensive **outpatient** psychotherapy.
78. **Reimbursed Claims.** Expenses which are paid or reimbursed as a result of legal action. This plan also excludes services for which a **covered individual** has received any payment or reimbursement from or on behalf of a responsible third party (person or organization), either by judgment or compromise, a portion of which has been designated for future medical expenses.
79. **Research Studies.** Charges associated with research studies.

80. **Riots.** Treatment or services relating to a riot.
81. **Rolfing.**
82. **School Provided Services.** Charges for services or items any school is required to provide under public law.
83. **Services Not Rendered.** Charges for services or supplies not rendered (including charges for canceled appointments).
84. **Sexual Conversion.** Surgical and other related medical charges associated with sexual conversion, gender reassignment, or disturbance of gender identification.
85. **Sexual Dysfunction.** Charges for the treatment of sexual dysfunction, except **medically necessary** penile implants.
86. **Skilled Nursing Facility.** Confinements for **mental disorders**, substance abuse and **custodial care**.
87. **Smoking Cessation.** Charges for services related to smoking cessation.
88. **Standby Physician.** Charges for a **standby physician**, except when required because of a **hospital** policy or state law or ordered by the delivering **physician** or surgeon.
89. **Sterilization Reversal.** Sterilization reversal and all related charges.
90. **Surrogacy.** Charges incurred by a **surrogate mother**.
91. **Thermography.** Charges for thermography, thermogram, or thermoscribe, except as otherwise provided.
92. **TMJ.** Charges related to appliances, x-rays and manipulations when related to the treatment of Temporomandibular Joint Syndrome (TMJ).
93. **Travel.** Any type of travel whether or not recommended by a **physician**, except in connection with covered ambulance and transplants.
94. **Vision.** Charges for radial keratotomy, LASIK, refractive keratoplasty or similar procedures, vision perception training or orthoptic training.
95. **Vitamin Injections.** Charges for vitamin injections, unless substitution with over-the-counter medication would endanger the patient's well being.
96. **War.** Charges incurred as a result of war or act of war, whether declared or undeclared.
97. **Weight Management.** Charges for weight management services, except as provided under the Comprehensive Plus Plan.
98. **Wigs.** Charges for wigs or hair prosthesis.
99. **Worker's Compensation.** Services rendered for treatment of any **injury** or **illness** for which benefits are available under a Worker's Compensation or Employer Liability Law.

COORDINATION OF BENEFITS (COB)

Today many people have more than one source of benefit coverage. Because of this, the plan has a coordination of benefits (COB) feature that helps to avoid duplication of payments for the same services. Not only does it prevent duplication of payments, it also makes sure that you are receiving the maximum benefit for which you are entitled.

How Does Coordination Work?

When there are other sources that provide benefits, the plan that pays benefits first is called the primary plan. The plan that pays benefits next is the secondary plan.

When this plan is primary, it will pay according to plan benefits described in this booklet. When it is secondary, the plan will use the "standard" method of coordination, which means the **Plan Supervisor** will calculate benefits and reduce its payment so that the total benefits paid under both plans do not exceed 100% of the allowable expense. However, even when the plan is secondary, it will never pay more than it would if were the primary plan.

The plan will also coordinate benefits on a secondary basis if the **covered individuals** have National Healthcare, such as Canadian residents.

Example:	Allowable expense	\$ 75
	Primary plan paid	<u>- \$ 60</u>
	Balance	\$ 15
	This plan would normally pay	\$ 60
	Payment by this plan as secondary	\$ 15

Example:	Allowable expense	\$250
	Primary plan deductible	<u>- \$200</u>
		\$ 50
	Primary plan payment @ 90%	\$ 45
	Allowable expense	\$250
	This plan's deductible	<u>-\$150</u>
		\$100
	This plan would normally pay @ 90%	\$ 90
	Allowable expense	\$250
	Primary plan paid	\$ 45
	Payment by this plan as secondary	\$ 90

How Does The Plan Coordinate Benefits When Multiple Preferred Provider Arrangements Are Utilized?

When both this plan, paying as secondary, and the primary plan have a preferred provider arrangement in place, payment will be made up to the preferred provider allowance available to the primary plan.

Determining The Order Of Benefit Payments

The following applies when determining whether this plan will be primary or will pay benefits secondary to another plan:

- If the other source of coverage does not contain a coordination of benefits provision, that source always pays benefits first.
- If the **claimant** is covered by this plan as an **employee** and has coverage through another source as a dependent (e.g., your spouse's plan), this plan is the primary plan and will pay benefits first. The other coverage, that provides benefits for the **claimant** as a dependent, will pay benefits second.
- If the **claimant** is covered by this plan as a **dependent** spouse and has coverage through another source as an employee, this plan is the secondary plan and will pay benefits second. The other coverage, which provides benefits for the **claimant** as an employee will pay benefits first.
- If the **claimant** is a child and is covered as a **dependent** under both this plan and the other parent's source of coverage, this plan will use the "birthday rule." The birthday rule means that the coverage of the parent whose birthday falls earlier in the year (regardless of the year of birth) is the primary plan and pays benefits first. The source providing coverage for the parent whose birthday falls later in the year pays benefits second. For example, if the mother's birthday is in June and the father's birthday is in August, the mother's source of coverage will pay benefits first. The age of the parent has no effect on whose coverage pays benefits first.
- If the **claimant** is a child of divorced or separated parents, the following order applies as to which source of coverage pays benefits first:
 - Parent with financial responsibility for medical, **dental**, or other health care expenses due to a court order;
 - If the court order does not establish financial liability, the parent with custody pays first, then the spouse of the parent with custody, then the parent without custody and spouse of the parent without custody.
- If none of the above guidelines applies, the source providing coverage for the **claimant** longer pays benefits first.

Other Instances Where The Plan Coordinates Benefits With Other Coverages

This plan also coordinates benefits with other types of coverage, as shown in the following charts. Please be sure to read the special rules regarding this plan's coordination with **Medicare**, which are immediately after the charts.

If You Have...	Here Is How This Plan Pays Benefits...
Coverage through your former employer, but not as a COBRA continuant or retiree	This plan pays benefits second.
COBRA continuation coverage through a former employer	This plan pays benefits first.
Retiree coverage through a former employer and you are not yet eligible for Medicare	This plan pays benefits first. Your former employer's retiree plan pays benefits second.
Retiree coverage through a former employer and you are eligible for Medicare (age 65 or older)	This plan pays benefits first. Medicare pays benefits second, and your former employer's retiree plan pays benefits third.
Coverage through Medicare as the result of end-stage renal disease	This plan pays benefits first and Medicare pays benefits second during the first 30 months of Medicare coverage. After 30 months, Medicare pays benefits first and this plan may or may not pay secondary benefits (depending on the amount Medicare pays).
Coverage through Medicare as the result of a disability or age	This plan pays benefits first as long as you are actively employed. If you are on a leave of absence and coverage continues during your leave, Medicare pays benefits first and this plan pays benefits second (or third after Medicare and your spouse's employer's plan - if applicable).
Coverage through Medicaid	This plan pays benefits first, any other plan through which you have coverage pays benefits second, and Medicaid pays benefits last.
Coverage through another government-sponsored program (e.g., TRICARE)	This plan pays benefits first, any other plan through which you may have coverage pays benefits second, and the government-sponsored program pays benefits last.
Coverage through National Healthcare, such as that available to Canadian residents	This plan pays benefits second to any National Healthcare coverage.
Coverage under this plan as a former employee through COBRA	This plan pays benefits second to any coverage provided through a plan covering you as an employee or dependent.
Coverage through an employer, but not as a COBRA continuant or retiree	The other plan pays benefits first, and this plan pays benefits second.

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** are eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If Your Spouse Has...	Here Is How This Plan Pays Benefits...
COBRA continuation coverage through another employer	Your spouse's current employer's plan pays benefits first, this plan pays benefits second (depending on the amount the other employer's plan pays), and COBRA continuation pays third.
Retiree coverage through a former employer and is not yet eligible for Medicare (younger than age 65)	The other plan pays benefits first, and this plan pays benefits second (depending on the amount the other plan pays).
Retiree coverage through a former employer, is eligible for Medicare (age 65 or older), and the retiree coverage supplements Medicare	This plan pays benefits first, Medicare pays second, and your spouse's retiree medical plan pays third.
Coverage through Medicare as the result of end-stage renal disease	<p>Your spouse's current employer's plan pays benefits first and Medicare pays benefits second during the first 30 months of Medicare coverage. If your spouse's coverage is provided as an active employee, this plan will pay second to your spouse's plan, and Medicare will pay third. If your spouse's coverage is provided as an inactive employee or a retiree, Medicare may pay benefits before this plan.</p> <p>After 30 months, Medicare pays benefits first, your spouse's other plan pays benefits next, and this plan may or may not pay a benefit (depending on the amount the other plan and Medicare pay).</p>
Coverage through Medicare as the result of a disability or age	<p>Your spouse's current employer's plan pays benefits first, as long as he or she is actively employed. If you are actively employed, this plan pays benefits second, and Medicare pays benefits third.</p> <p>If your spouse's coverage is provided as an inactive employee or a retiree, Medicare may pay benefits before your spouse's coverage and before this plan.</p> <p>If your spouse's only coverage is through this plan and you are an active employee, this plan pays benefits first and Medicare pays benefits second. If you are not actively employed (whether or not your spouse has other coverage), this plan pays benefits after any other plan (including Medicare).</p>
Coverage through Medicaid	Your spouse's current employer's plan pays benefits first, this plan pays benefits second (depending on the amount the other employer's plan pays), and Medicaid pays benefits last.
Coverage through another government-sponsored program (e.g., TRICARE)	Any other plan through which your spouse may have coverage pays benefits first, this plan pays benefits second, and the government-sponsored program pays benefits last.
Coverage through National Healthcare, such as that available to Canadian residents	This plan pays benefits second to any National Healthcare coverage.
Coverage under this plan through COBRA	This plan pays second to any coverage covering your spouse as an employee or dependent.

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** are eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If Your Child Has...	Here's How This Plan Pays Benefits...
Coverage under this plan through COBRA	This plan pays second to any coverage covering your child as a dependent.
Coverage through Medicaid	This plan pays first.
Coverage through another government-sponsored program (e.g., TRICARE)	Any other plan through which your child may have coverage pays benefits according to the priority previously described, and the government-sponsored program pays benefits last.
Coverage through National Healthcare, such as that available to Canadian residents	This plan pays benefits second to any National Healthcare coverage.
Coverage through Medicare as the result of end-stage renal disease	<p>The plan responsible for your child's primary coverage (as previously explained) pays benefits first and Medicare pays benefits last during the first 30 months of Medicare coverage.</p> <p>After 30 months, Medicare pays benefits first, and the above rules governing the order of benefit payments apply next. This plan may or may not pay a benefit (depending on the amount any other plan and Medicare pay).</p>

IMPORTANT NOTE REGARDING MEDICARE: If you or your covered **dependent** are eligible for Medicare Parts A and/or B, this plan will assume you have enrolled in **Medicare** coverage and will coordinate benefits accordingly, regardless of whether you actually enrolled in **Medicare**.

If you or any member of your family has more than one source of coverage, contact the **Plan Supervisor** to get a complete understanding of how the COB feature applies.

Coordination Of Benefits With Medicare

For purposes of this plan, **Medicare** coverage will be assumed if you are eligible, whether or not you have actually enrolled in Part A or Part B.

A person is "eligible for **Medicare**" if he/she:

- is covered under it;
- refused it;
- dropped it; and/or
- failed to make a proper request for it.

If, according to the above, a person is eligible for **Medicare** and if **Medicare** is the primary payor, regular benefits under this plan may be reduced by benefits paid by **Medicare** if the total of the benefits payable under both plans would exceed 100% of the covered allowable expense. In no event will this plan pay more than the regular benefits payable in the absence of other coverage.

Coordination Of Benefits With Auto Insurance Policy

Coverage provided by the plan shall be coordinated with coverage provided pursuant through the no-fault insurance law or policy of any State or Canadian Province, or of any sovereign nation or political subdivision. The coverage provided by the plan for medical expenses incurred as a result of a motor vehicle accident is secondary to any coverage for motor vehicle related medical expenses provided for by any no-fault insurance law or policy. The coverage provided by the plan for medical expenses incurred as a result of a motor vehicle accident shall be coordinated with the coverage provided under any insurance policy, bond, fund or other arrangement in effect pursuant to any no-fault insurance law in such a manner that in all cases, the coverage provided by the plan shall be deemed secondary and the no-fault coverage shall be deemed primary. In determining the coverage of the plan, any provision of no-fault coverage which attempts to coordinate that coverage with the plan so that the plan coverage would be primary, shall be disregarded.

Claims for medical expenses incurred as a result of a motor vehicle accident must first be submitted to the applicable no-fault insurance carrier. Any eligible expenses which are not paid by that carrier will be considered for payment by the plan. Otherwise eligible expenses will not be reimbursed by the plan where the failure to pay by the no-fault carrier is the result of:

- A coordination of benefits, excess insurance or "other insurance" provision of the no-fault insurance policy would operate to shift primary liability to the plan; OR
- An untimely claim (unless good and sufficient reason acceptable to Port Huron Hospital is shown for your inability to submit such claim or to have such claim submitted by someone else on behalf of the covered **employee/dependent**); OR
- Medical expenses not being covered under the motor vehicle policy for any reason, including, but not limited to, a decision by the insured to decline such coverage.

Any payments in connection with a motor vehicle accident which, by virtue of the application of this coordination of benefits provision, are payments in excess of the plan's obligations, may be recovered by the plan and/or offset against any payments which otherwise are due or become due.

PARTICIPATING IN THE PLAN

1. Who Can Participate In The Plan?

You are eligible for coverage in this plan if you are an individual who is actively employed by the **Corporation** as either a full-time or part-time II (minimum assigned hours of twenty-four (24) per week – please refer to the Employee Handbook for further details).

2. When Can I Participate In The Plan?

As an eligible **employee**, you may participate in the plan described in this booklet on the first day of the month following 90 days of active employment. Human Resources will provide you with an **enrollment form**. Please note that **employees** may purchase and pay the full cost of medical coverage during the waiting period.

3. How Do I Enroll For Coverage?

You must complete, sign and return your **enrollment form** to Human Resources within 30 days from your **coverage effective date** for you to be covered in this plan.

4. Can I Enroll My Spouse And Dependent Children?

Yes. If you enroll for coverage, you may also enroll your eligible spouse and **dependent** children.

5. How Do I Know If My Spouse Is Eligible?

Your spouse is eligible if you are legally married and neither legally separated nor divorced. This plan will not recognize same gender marriages or common law marriages, whether or not such marriages are legal or valid under the laws of your state of residence or the state in which the ceremony occurred.

Verification of your spouse's eligibility is required at the time of enrollment.

6. What If Both My Spouse And I Work For The Corporation?

If both you and your spouse are covered as **employees** under this plan, both of you may enroll your children as **dependents**, and may also be considered **dependents** under each other's plan.

If both you and your spouse are covered separately as **employees** and coverage for one of you is terminated, the one who remains an **employee** may, within 30 days, cover their spouse as a **dependent** and may cover any children who were covered under the spouse's coverage.

See questions 13 through 20 for more information.

7. How Do I Know If My Dependent Children Are Eligible?

If you enroll for coverage, you may also enroll your eligible **dependent** children. Verification of your **dependent** children's eligibility is required at the time of enrollment. Please refer to the chart below for eligibility requirements:

Eligible dependents	Requirement
Your dependent children	<p>Your unmarried children up to the end of the month in which they reach age 19.</p> <p>Children are your:</p> <ul style="list-style-type: none"> • natural born children, • step children, • legally adopted children, • children for whom you have court appointed guardianship, • children under age 18 who have been placed for adoption, whether or not the adoption is final. Proof of adoption of placement for adoption is required for enrollment in the plan.
Students age 19 and older	<p>Your unmarried children until the end of the month in which they reach age 25 provided they are full-time students (as defined by the institution) in an accredited secondary school, college, university or trade school (proof may be required), and are not employed on a full-time basis. Please note that these eligible dependents will remain eligible for coverage during school recesses or summer vacation, provided they were enrolled as full-time students in the school term preceding the recess or vacation and they are enrolling for the school term following the recess or vacation.</p> <p>If your child takes a medically necessary leave of absence during a school term due to a serious illness or injury, he or she will be considered a full-time student until the earlier of:</p> <ul style="list-style-type: none"> – one year from the start of the medically necessary leave; or – the date on which coverage would otherwise terminate under the terms of the plan. <p>Written certification must be provided by the attending physician of your dependent child certifying that the child is suffering from a serious illness or injury that would require a medically necessary leave of absence.</p>
Totally disabled children	<p>Your unmarried children who are mentally or physically totally disabled may continue their participation in the plan after the end of the pay period in which they reach age 19 or 25 (if over age 19 and covered due to being a full-time student) provided they were enrolled in the plan prior to their 19th or 25th birthday. Proof of the child's incapacity must be provided within 120 days following the child's 19th or 25th birthday, and must be provided annually thereafter.</p> <p>Coverage will continue as long as the child is totally disabled, provided that coverage does not terminate for any other reason.</p>
Court ordered coverage	The plan will provide coverage for eligible dependent children whom you have been ordered by a court to provide coverage.
QMCSO	This plan will also provide coverage as described by a Qualified Medical Child Support Order (QMCSO) that assigns the rights of a participant or beneficiary to receive benefits under this health plan.

8. What If A Court Order Requires That I Provide Coverage For My Dependent Child?

A Qualified Medical Child Support Order (QMCSO) is a court decree under which a court mandates coverage for a child (called an Alternate Recipient). Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the Plan Sponsor shall take the following steps, within 20 business days:

1. Determine if the notice or order conforms to the requirements of a QMCSO,
2. Reply to the issuing agency if you are no longer employed, fall into a class of **employees** who are ineligible for coverage or if **dependent** coverage is not provided,
3. Notify the issuing agency if the notice or order is determined to not meet the requirements of a QMCSO,
4. Notify the issuing agency of the coverage options available under the plan and any waiting periods which exist for coverage under the plan (if applicable),
5. Determine if federal withholding limits or prioritization rules permit the withholding from your income of the amount required to obtain coverage for the children specified,
6. If appropriate, withhold from your income any contributions required,
7. Notify you of any contributions to be withheld from future pay,
8. Notify **Plan Supervisors**/vendors about enrollment, and
9. Notify the issuing agency of the date of enrollment and date coverage under the plan will begin.

The participant and each Alternate Recipient shall have the right to request in writing that the Plan Sponsor again review the status of the notice or order. The request must be submitted within 60 days after being notified of the Plan Sponsor's decision. The participant and each Alternate Recipient may present additional materials to the Plan Sponsor for review. The Plan Sponsor may request additional information or material from the participant or Alternate Recipient. The Plan Sponsor must provide sufficient information to understand available options and to assist in appropriately completing the notice or order.

9. What If My Dependent Children Have Other Coverage?

The eligibility of your **dependent** children under this plan will in general follow the "birthday rule." You are probably wondering what the birthday rule is. The birthday rule means the parent whose birth date occurs first in the year has primary responsibility for coverage. For example, if your spouse's birth date occurs first in the year, your spouse's group coverage would be primary for your **dependent** children.

If a court decree or child custody agreement establishes which parent must provide primary coverage; this plan will follow the court decree or child custody agreement. For other circumstances, refer to the section titled "Coordination of Benefits (COB)."

10. Who Would Not Be Considered Eligible For Enrollment In This Plan?

- You and your **dependents**, on the date your employment terminates or the date you no longer meet eligibility requirements as defined in this plan, except as otherwise provided.
- Your spouse beginning on the date you are legally divorced or legally separated.
- Any individual who begins active service in the armed forces of any country, unless coverage is continued as provided under Federal law.
- Any individual who does not meet the definition of an **employee** or **dependent**.
- Anyone for whom required contributions toward the cost of coverage have stopped without the permission of the **Corporation**.

NOTE: If your coverage terminates or if a **dependent** ceases to be covered for any of the above reasons, you and/or your **dependent** may be eligible to continue coverage under the plan through **COBRA**.

11. What Is My Cost To Participate In The Plan?

Port Huron Hospital pays most of the cost of providing benefits to you and your **dependents**. However, you are responsible for your portion of the cost, as well as the full premium costs for **dependents** age 19 to 25 who are college students.

12. Can I Opt-Out Of The Plan?

If you and your **dependents** have other group health coverage or another health insurance arrangement, you may elect to waive coverage in this plan. If you elect to waive coverage in the plan during the **annual open enrollment period**, you may be eligible for a taxable cash allowance. To be eligible for this allowance you must certify that you have existing medical coverage, and waive coverage for the entire calendar year. If you enroll in the plan at any time during the year, you will be required to repay the cash allowance you received based upon your waiver of coverage. Please contact Human Resources for additional information.

If you elect to waive out of this plan, there are certain limited circumstances in which you may change your election. Please refer to questions 13 through 20 for further information.

If you choose to drop coverage or “waive out” of the medical plan during the **plan year**, you will not receive any financial reimbursement from the **Corporation**.

13. Can I Enroll Myself And/Or My Dependents If I Previously Declined Participation In The Plan?

If you are an eligible **employee**, you may have the opportunity to enroll yourself and **dependents** at open enrollment. During this time, you will have an opportunity to select the coverage that is best for your family. The **annual open enrollment period** is held once each year during the fall. You may enroll or transfer into any plan maintained by the **Corporation** for benefits and change the eligible **dependents** you cover. Elections made during the **annual open enrollment period** will be effective on the first of January of the following year.

If you declined enrollment for yourself or your **dependents** and you or your **dependents** become eligible for a premium assistance subsidy under Medicaid or Children's Health Insurance Program (CHIP), you may enroll yourself and **dependents** in this plan within 60 days of when eligibility for the subsidy was determined.

If you declined enrollment for yourself or your **dependents** and coverage under Medicaid or Children's Health Insurance Program (CHIP) is terminated as a result of loss of eligibility, you may enroll yourself and **dependents** in this plan within 60 days of the loss of coverage.

If you declined enrollment for yourself or your **dependents** because you or your **dependents** have other group coverage or another health insurance arrangement, you may, in the future, be able to enroll yourself or your **dependents** in this plan due to a qualifying event, provided you request enrollment within 30 calendar days after your other coverage ends. Please refer to Question 19 for additional information.

14. Does The Plan Have A Pre-Existing Condition Limitation?

Yes. If you or your covered **dependents** have any physical or psychoneurological condition regardless of the cause of the condition, for which medical advice, **diagnosis**, care or treatment was recommended or received within the 3-month period immediately prior to the **enrollment date**, the condition would be considered pre-existing. However, a **pre-existing condition** does not include a condition affecting newborn children, newly adopted children (or children placed for adoption), or the condition of pregnancy.

15. What Is The Pre-Existing Waiting Period?

The **pre-existing condition waiting periods** are the additional waiting periods that apply to expenses incurred after the **enrollment date** if those expenses are related to a **pre-existing condition**. This waiting period will continue for up to 6 months of continuous coverage after the **enrollment date** for **employees**, and up to 12 months of continuous coverage after the **enrollment date** for covered **dependents**. Benefits are not payable by this plan for a **pre-existing condition** during the **pre-existing condition waiting periods**.

16. Will I Have Coverage For My Or My Dependent's Pre-Existing Condition?

Yes, you will have coverage for your or your **dependent's pre-existing condition** after the applicable pre-existing waiting period unless you have prior **creditable coverage**. Benefits are not payable by this plan for a **pre-existing condition** during the **pre-existing condition waiting periods**.

These periods will be reduced by one day for each day of prior **creditable coverage** (as defined by the Health Insurance Portability and Accountability Act of 1996 - HIPAA).

17. What Information Do I Need To Enroll During The Year?

If you have a new **dependent** as a result of marriage, birth, adoption or placement for adoption, you may be able to enroll yourself, your spouse and your **dependent** child, provided you request enrollment within 30 calendar days after the marriage, birth, adoption or placement for adoption. You must provide Human Resources with the following information in writing and provide written documentation of the event (i.e., birth certificate, marriage license, etc.) within that 30 calendar day period:

1. The reason for the addition (e.g., newborn baby, adoption, marriage, full-time student, etc.)
2. The name of each **dependent**
3. Their relationship to you
4. Their dates of birth
5. The date they became your **dependents** (e.g., newborn baby – date of birth; adoption – date of adoption; marriage – date of marriage)
6. Their social security number

If you add your **dependent(s)** within the 30-day period specified above, their coverage will be effective as of the date they became your **dependent(s)**. If they are not added at that time, they may only be added as described above in Question 13.

18. Are There Other Changes I Need To Provide To Human Resources?

To keep your coverage up-to-date, you should notify Human Resources immediately whenever your personal status or that of your **dependents** changes in such a way as to affect your coverage. Typically changes of this sort occur when:

- you move,
- you marry,
- you have a child,
- you are divorced,
- a covered **dependent** becomes ineligible, and
- there is a change in your spouse's or **dependent's** health coverage.

19. Can I Change My Coverage During The Year?

IRS regulations require that your benefit elections remain in effect throughout the full **plan year** (January 1 – December 31). The only exception that permits you to change your election during the year is when you experience a qualified change in family status. When you do experience a qualified change in family status, your mid-year election changes must be consistent with the following requirements:

- The event must cause you or your **dependent** to gain or lose eligibility for:
 - benefits under one of the benefit plans;
 - benefits available through the cafeteria plan; or
 - benefits available under another employer's benefit plan or plan option.
- The mid-year election change must be "on account of" the change in status; and
- The mid-year election change must "correspond with" the change in status that caused a gain or loss of plan eligibility.

The following chart explains which events are considered qualified changes in family status and what changes you may make as a result.

Event	Enrollment Procedure
Change in marital status	You may add your spouse and children, drop coverage or change coverage as a result of marriage. You may delete spouse/add dependents due to a divorce, legal separation or annulment. You may delete spouse/add dependents or change coverage due to the death of a spouse.
Change number of dependents	You may add your children/spouse or change coverage as a result of a birth, adoption or placement for adoption. You may delete dependent /change coverage due to a death of a dependent child.
Change in employment status or work schedule of the employee , spouse or dependent	You may drop coverage/add coverage, delete spouse or dependent or change coverage as the result of commencement or termination of employment, change in worksite, commencement or return from leave of absence, change from part-time to full-time employment or vice-versa, strike or lock-out, or change from salaried to hourly pay. Rehires will be treated like new employees and allowed new elections.
Significant change in coverage or in cost of coverage (as determined by the Corporation)	You may drop coverage/add coverage or change coverage if the change in coverage or in cost of coverage affects eligibility under another group health plan for you or your spouse due to your spouse's employment.
Change in residence of the employee , spouse or dependent	You may drop coverage or change coverage if you move, provided the move causes you or your dependent to gain or lose eligibility.
Dependents gain or lose eligible status	You may add/drop coverage of a dependent that is meeting or ceasing to meet the plan's definition of dependent , such as attainment of a specified age or ceasing to be a student.
Mid-year eligibility for or loss of Medicare or Medicaid	You may add/drop coverage or delete dependent as a result of gain or loss of Medicare or Medicaid coverage.
A judgment, decree or order requiring dependent coverage (e.g., QMCSO)	You may add coverage and dependent child due to a judgment, decree or order requiring dependent coverage.

20. What Should I Do If I Experience A Family Status Change?

If you have a qualified change in family status, please contact Human Resources immediately so that they can provide you with the information you will need to make any changes allowed under this plan. You must make these changes within 30 days of the event. Changes will be effective on the date of the event.

21. When Will My Coverage And/Or My Dependents Coverage End?

Your coverage

Your coverage will end at the end of the month in which any of the following occur:

- you are no longer an eligible **employee** (except as otherwise provided under questions 22 through 30),
- you stop making required contributions without permission of the **Corporation**,
- you decline coverage,
- you leave employment at the **Corporation**,
- you retire (you may or may not qualify as an eligible retiree under the retiree benefit plan),
- you die,
- the plan is terminated, or is amended such that you do not meet the requirement for coverage under the plan.

Your dependent's coverage

Coverage for your **dependents** will end at the end of the month in which any of the following occur:

- your coverage ends (except as otherwise provided under question 22),
- your **dependent** no longer meets the plan's requirement of an eligible **dependent**,
- you stop making required contributions without permission of the **Corporation**,
- you decline coverage for your eligible **dependents**,
- you retire,
- the plan is terminated, or is amended such that you or your **dependent** do not meet the requirement for coverage under the plan.

When coverage ends for you and your covered **dependents** as provided above, you and/or your covered **dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to the section titled "COBRA Continuation Coverage."

In certain circumstances your coverage may be extended. These situations are described in the following few questions. As always, please refer to your Employee Handbook for complete details.

22. What Happens To My Dependents' Coverage If I Pass Away?

Coverage for covered **dependents** will continue until the end of the month following the month in which your death occurred. Your **dependents** must pay the regular contribution for coverage for the period for which contributions may be taken from your last pay. Contributions will be waived for the remaining period of coverage.

Your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage."

23. What Happens To My Coverage If I Am Laid Off?

If your employment is impacted through a reduction in work force (layoff), then coverage for you and your covered **dependents** will continue as described in any applicable employment policy and/or employee handbook.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage."

24. What Happens To My Coverage If I Take An Approved Personal or Educational Leave Of Absence?

Coverage for and your covered **dependents** will continue as described in any applicable employment policy and/or employee handbook.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage."

25. What Happens To My Coverage If I Go On An Approved Work Related Medical Leave?

Your coverage and that of your covered **dependents** will continue as described in any applicable employment policy and/or employee handbook.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage."

26. What Happens To My Coverage If I Go On An Approved Non-Work Related Medical Leave?

Your coverage and that of your **dependents** will continue as described in any applicable employment policy and/or employee handbook.

You and your **dependents** may then be eligible for continuation of coverage as explained in the section titled "COBRA Continuation Coverage."

27. What If I Return To Work From My Medical Leave, Personal Leave Of Absence Or Layoff?

If you return to work following your medical leave or personal leave of absence or layoff, coverage for you and your covered **dependents** will be reinstated as described in any applicable employment policy and/or employee handbook.

28. Do I Have Continuation Rights Under USERRA If I Am On Military Leave?

You may elect to continue coverage under the plan (including coverage for **dependents**) for up to 24 months from the first day of absence (or, if earlier, until the day after the date you are required to apply for or return to active employment with the **Corporation** under the Uniformed Services Employment and Reemployment Rights Act of 1994. If your period of military service is less than 31 days, you will be required to pay your normal contributions for coverage. If your period of military service is 31 days or more, your contributions for the continued coverage shall be the same as for a **COBRA** beneficiary.

Whether or not you continue coverage during military service, you may reinstate coverage under this plan upon your return to employment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994. The reinstatement will be without any **pre-existing condition** exclusion or waiting period otherwise required under the plan, except to the extent that the exclusion or waiting period would have been imposed if coverage had not terminated due to military service. This waiver of the exclusion and waiting period shall not apply to any **illness** or **injury** that is incurred in, or aggravated during, the performance of military service.

29. Do I Have Continuation Rights Under FMLA If A Member Of My Family Is Called To Active Military Leave Or Is Injured While On Active Military Duty?

The Family Medical Leave Act of 1993 (FMLA), as amended effective January 28, 2008 provides rights to certain family members of **employees** who are individuals in the service of the United States Armed Forces. These benefits include the extension of health benefits and the resumption of benefits upon return from the leave. For specific information, please refer to the Port Huron Hospital Comprehensive Welfare Plan.

30. What Happens To My Coverage If I Take A Leave Under The Family And Medical Leave Act (FMLA) (For A Reason Other Than Military Leave)?

The Family and Medical Leave Act of 1993 (FMLA) provides certain rights to qualified **employees**. Included in these rights are certain provisions regarding the extension of health benefits and the resumption of benefits for **employees** who are granted leave. For specific information, please refer to the Port Huron Hospital Comprehensive Welfare Plan.

GLOSSARY

Whenever one of the following words or phrases appears highlighted, they shall have the meaning explained below, unless the context otherwise requires. Please note, “**reasonable and customary**,” “**experimental**,” “**investigational**” and “**medically necessary**” have been defined elsewhere in this SPD.

Adverse benefit determination: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on the determination of a participant’s or beneficiary’s eligibility to participate in the plan. This includes a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit resulting from the application of any utilization review (if applicable), as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be **experimental** or **investigational** or not **medically necessary** or appropriate.

Ambulatory surgical center: a facility which meets all of the following requirements:

- has an organized staff of **physicians**,
- has permanent facilities that are primarily for **surgery**,
- provides continuous **physician** and nursing services,
- does not provide overnight accommodations, and
- does not include a **physician’s** or **dentist’s** office for the practice of medicine or dentistry.

Annual open enrollment period: an annual period each fall, during which you may enroll into the plan for benefits to be effective on the following January 1.

Authorized representative: a **physician** rendering the service for which a bill is submitted (but not a designee of the **physician**), or a person who a covered **employee** or covered **dependent** has authorized in writing to act on his/her behalf. If the claim is an urgent care **pre-service claim**, the plan will consider a **health care professional** with knowledge of a **claimant’s** medical condition as an **authorized representative**.

If a covered **employee** or covered **dependent** wishes to authorize another person (e.g., family member) to act on his/her behalf on matters that relate to filing of benefit claims, notification of benefit determinations, and/or appeal of benefit denials, he/she must first notify the **Plan Administrator** of such authorization by providing a completed Notice of Authorized Representative form. The Notice of Authorized Representative form can be obtained from Human Resources.

Birth center: a facility that is licensed by the state in which it is located to provide pre-natal, birth, post-partum, newborn and gynecologic services to pregnant women.

Cardiac rehabilitation program: a specialized exercise program conducted at a **Medicare** approved **outpatient hospital** department or a freestanding cardiac rehabilitation clinic.

Certified Nurse Midwife: a Registered Nurse (RN), Licensed Practical Nurse (LPN), or Licensed Vocational Nurse (LVN) who has completed a course of study and has been certified and licensed as a midwife.

Claimant: an eligible **employee**, a covered **dependent** or an **authorized representative**.

Claims Administrator: your plan has different **Claims Administrators** based on the type of claim. The **Claims Administrator** for each type of claim is responsible for claim processing within the time periods listed for initial claims determination as well as for the final decision for any appeal filed in response to an **adverse benefit determination**. Each is independently, responsible for notifying you of the **adverse benefit determination**, based on the type of claim, as well as reviewing any appeal you may make. Your **Claims Administrators** and the address where to file appeals are as follows:

Post-Service Claims: (Medical) NGS, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

Post-Service Claims: (Pharmacy) Port Huron Hospital, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108.

Each **Claims Administrator** shall have final discretionary authority to construe the terms of the plan, for purposes of final claims determinations, for those claims listed above for which they are designated as the **Claims Administrator**.

COBRA: the Consolidated Omnibus Budget Reconciliation Act of 1986 that requires group health plans to provide **employees** and eligible family members the opportunity to continue health care coverage at their own expense, when coverage would be lost under certain circumstances.

Concurrent claims decision: a decision by the plan relating to an ongoing course of treatment.

Concurrent hazardous medical condition: a potentially life-threatening condition, substantiated by the patient's attending **physician**, requiring care with immediate access to **hospital** equipment. (For the purpose of **hospital confinement** for **dental** procedures, conditions such as hemophilia, uncontrollable diabetes and hypertension will be considered **concurrent hazardous medical conditions**.)

Congenital defect (also referred to as birth defect): a physical abnormality existing at birth.

Coronary care unit: a segregated unit, concentrating all necessary types of equipment, together with skilled nursing, for monitoring a patient's heart condition.

Corporation: Port Huron Hospital, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108.

Coverage effective date: the date on which the **employee's** and/or his/her eligible **dependent's** benefits begins. (Please refer to the section titled "Participating in the Plan" for more information.)

Coverage termination date: the date on which the **employee's** and/or his/her **dependent's** benefits ends. (Please refer to the section titled "Participating in the Plan" for more information.)

Covered individual: an eligible **employee**, **covered spouse** or **dependent** that is enrolled in the Port Huron Hospital Medical Benefits Plan as Amended and Restated January 1, 2010. (This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan".)

Covered spouse: the **employee's** current legally married husband or wife who is enrolled in the Port Huron Hospital Medical Benefits Plan as Amended and Restated January 1, 2010. (This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan".)

Creditable coverage: coverage an individual has under a group health plan, Medicaid, **Medicare** and public health plans, as well as other types of coverage set forth in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 that may be used to satisfy this plan's **pre-existing condition waiting period**.

Custodial care: services provided to an individual which are not necessarily medically required, but which primarily help an individual perform daily living activities (example: services normally rendered in a nursing home).

Deductible: a specific dollar amount that a **covered individual** must pay (or "satisfy") in covered expenses each calendar year before the plan pays its share of covered expenses. (Please refer to the section titled "What is the Plan Deductible?" for further information.)

Dental: relating to the teeth or gums.

Dentist(s): 1) a legally licensed Doctor of Dental Surgery (DDS) or Doctor of Medical Dentistry (DMD) practicing within the scope of his/her license who is permitted to perform services for which coverage is provided in this plan. 2) a legally licensed **physician** authorized by his/her license to perform the particular **dental** procedure for which coverage is provided in this plan.

Dependent: people who have a relationship to an **employee**. This includes only those people who qualify for enrollment as indicated in the section titled "Participating in the Plan".

Diagnosis: a descriptive statement of a medical or **dental** condition.

Employee: an individual who is actively employed by the **Corporation** and whose assigned hours are twenty-four (24) hours or more per week.

Enrollment date: the earlier of the date your coverage begins or the date your waiting period for coverage begins. For a late enrollee, the **enrollment date** is the first day of coverage.

Enrollment form: the form provided by the employer for your completion and signature to enroll you and your **dependents** in the medical plan.

Health care professional: a **physician** or other **health care professional** licensed, accredited, or certified to perform specified health services consistent with state law.

Home health care agency: a public or private agency legally operating in the state in which it is located, that provides nursing services administered in a person's home by a Registered Nurse (RN), a Licensed Practical Nurse (LPN), a Licensed Vocational Nurse (LVN), or by a home health aide who is employed by the **home health care agency**.

Hospice: a health care program providing a coordinated set of services rendered at home, in **outpatient** settings or in institutional settings for **covered individuals** suffering from a condition that has a terminal prognosis. A **hospice** must have an interdisciplinary group of personnel that includes at least one **physician** and one Registered Nurse (RN), and it must maintain standards of the National Hospice Organization (NHO) and applicable state licensing requirements.

Hospital: a state licensed **inpatient** institution or facility that meets all of the following requirements set forth (A), (B) or (C) below:

- A • It is accredited by state, national, medical or **hospital** authorities; or
- It is listed in the American Hospital Association member directory.
 - It is open at all times.
 - It provides diagnostic services and therapeutic services and organized facility for major **surgery** on the premises for the surgical and/or medical treatment of ill and injured persons.
 - The treatment is by or under the direct supervision of a licensed **physician(s)** or surgeon(s).
 - The facility continuously provides 24-hour nursing services by Registered Nurses (RN).
 - It is not - other than incidentally - a place for convalescent care, for rest, for the aged, for alcoholics, for drug addicts, for pulmonary tuberculosis or a nursing home.
- B • It is a licensed psychiatric, substance abuse or tuberculosis facility recognized by the regulatory authority to provide treatment primarily for **mental disorders**, substance abuse or tuberculosis treatment.
- C • It is an **inpatient** facility that provides restorative services to **inpatients** under the direction of a **physician** knowledgeable and experienced in rehabilitative medicine.

Hospital confinement: the period of time an individual spends in a **hospital** as an overnight bed patient (**inpatient**).

Illness: the condition of being sick or unhealthy as classified in the current International Classification of Diseases (ICD).

Infertility: the inability or diminished ability to produce offspring.

Injury: a sudden, unexpected and unforeseen bodily harm that occurs solely through external bodily contact. This includes strains and spasms.

Inpatient: an individual who is officially admitted to a **hospital** as a bed patient and occupies a **hospital** bed a minimum of 18 hours while receiving **hospital** care, which includes room, board and general nursing care.

Intensive care unit: a segregated unit concentrating all necessary types of equipment together with skilled nursing care. (This can include coronary care and intensive isolation.)

Learning disability: inability or defect in ability to learn. Typically this occurs in children and is manifested by difficulty in learning basic skills such as writing, reading and mathematics.

Life-threatening medical emergency: a condition having symptoms which occur suddenly and unexpectedly and result in an urgent need for immediate medical attention as determined and reported by the **physician** that the patient's life is endangered, including - but not limited to - heart attacks, acute hemorrhages, strokes and convulsions.

Long term acute care facility: a specialized facility that meets the needs of patients who require acute medical care services for an extended period, after initial **diagnosis** and treatment have occurred. Nursing homes or **skilled nursing facilities** are not considered **long term acute care facilities**.

Medicare: a Federal program through the Social Security System that provides benefits for **hospital** and **physician** care. This includes a Health Maintenance Organization (HMO) that participates with **Medicare** and receives payment from **Medicare**. (It is available on an enrollment basis to individuals receiving dialysis treatment beyond 30 months, individuals eligible for Social Security benefits if they are age 65 or older or those individuals who have qualified for Social Security disability benefits and have received such disability benefits for 24 months.)

Mental disorder: a clinically significant behavior or psychological syndrome or pattern that is typically associated with either a distressing symptom or impairment of function and requires psychiatric care for any reason, or an organic or biological condition which requires psychiatric care for any reason.

Network provider: **Port Huron Hospital**, any entity of Blue Water Health Services, and/or a facility or medical practitioner who has a signed contract with Port Huron Hospital and/or a **Regional PPO network** and any medical staff member of Port Huron Hospital who is a **Regional PPO network** member.

Non-network provider: a facility or medical practitioner who does not have a contract with Port Huron Hospital and/or a **Regional PPO network**.

Nurse: a Registered Nurse (RN), a Licensed Practical Nurse (LPN), or a Licensed Vocational Nurse (LVN) who provides nursing care who is not a member of the patient's family or resides in the household.

Observation: a **hospital** classification for a person who is not admitted as an **inpatient**, but who requires ongoing assessment or monitoring.

Occupational therapist: a **health care professional** licensed, accredited, registered or certified to perform occupational therapy consistent with state law.

Orthotics: devices that are rigid and semi-rigid supporting devices which restrict or eliminate motion of a weak or diseased body part.

Out-of-pocket maximum: the maximum amount of out-of-pocket expenses you have to pay each calendar year for certain covered medical expenses. (Please refer to the section titled "What is your Out-Of-Pocket Maximum?" for further information.)

Outpatient: an individual who receives medical care, treatment, services or supplies at a clinic, **physician's** office or at a **hospital** if not a registered bed patient at that **hospital**.

Physical therapy: physical evaluation (including muscle testing) for a **covered individual** and certain therapeutic treatments professionally administered by a **physical therapist**, Physical Therapy Assistant (PTA) or Certified Athletic Trainer (ATC), to aid in the recovery from **illness** or **injury**, including - but not limited to - diathermy, gait training, hot or cold packs, manual traction, massage, mechanical traction, prosthetic training and whirlpool. **Physical therapy** activities are designed to help the **covered individual** attain greater self-sufficiency, mobility and productivity through exercises and externally applied heat, electroshortwave, hydrotherapy and other mechanical modalities intended to improve muscle strength, joint motion, coordination and general endurance.

Physical therapist: a health care professional licensed, accredited, registered or certified to perform **physical therapy** consistent with state law.

Physician: a qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Podiatry (DPM), Doctor of Chiropractic (DC), Doctor of Optometry (OD), Doctor of Dental Surgery (DDS or DMD), **Psychologist** (PHD), who, within the scope of their licenses, are legally permitted to perform services for which coverage is provided in this plan.

This plan will also cover the services of a Certified Registered Nurse Anesthetist (CRNA), Physician's Assistants and Certified Nurse Practitioners, who are under the direction of a **physician**; Chemical Dependency Counselors, who are under the direction of a **psychiatrist** or **psychologist**; as well as other providers who are not physicians, but who are specifically mentioned as covered providers in the plan.

Plan Administrator: Port Huron Hospital, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108.

Plan Document: the legal description of and the governing document for this plan.

Plan Supervisor: NGS, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

Plan year: begins on the first day of January and ends on the last day of the following December.

Port Huron Hospital (Provider): an entity of Blue Water Health Systems Corporation, a facility or agency who has a signed contract with Port Huron Hospital to provide services under this plan and any medical staff member of Port Huron Hospital who is also a **Regional PPO network** member. This includes all Port Huron Hospital subsidiaries and affiliates. However, certain services must be provided at Port Huron Hospital to be paid at the **Port Huron Hospital** and Affiliates benefit level. For those services, the subsidiary or affiliate is not considered to be a part of "**Port Huron Hospital and Affiliates**" for purposes of determining the level of benefits. Please refer to the section titled "Are There any Services that Must Be Rendered at Port Huron Hospital in Order to Receive the Port Huron and Affiliates Level of Benefits?" for specific information.

Post-service claim: any claim for a benefit under this plan that is not a **pre-service claim**. In other words, a claim that is a request for payment under the plan for covered services that a **claimant** has already received.

Pre-existing condition: is any physical or psychoneurological condition regardless of the cause of the condition, for which medical advice, **diagnosis**, care or treatment was recommended or received within the three-month period ending on the **enrollment date**. A **pre-existing condition** does not include a condition affecting newborn children, newly adopted children (or children placed for adoption) or the condition of pregnancy.

Pre-existing condition waiting periods: are the additional waiting periods which apply to expenses incurred after the **enrollment date** if those expenses are related to a **pre-existing condition**. These waiting periods will continue for up to 6 months after the **enrollment date** for **employees** and up to 12 months after the **enrollment date** for **dependents**.

These periods will be reduced by one day for each day of prior **creditable coverage** (as defined by the Health Insurance Portability and Accountability Act of 1996) presented by the **covered individual**.

Prescription drug: those drugs approved by the Food and Drug Administration of the United States which require a written prescription by a **physician** or **dentist** and which bear the legend, "Caution: Federal law prohibits dispensing without a prescription."

Pre-service claim: any claim for a benefit under this plan where the plan conditions receipt of the benefit, in whole or in part, on approval in advance of obtaining medical care.

- **Urgent Care Claim:** A **pre-service claim** may be an urgent care claim if it is for medical care or treatment where using the timetable for a non-urgent care determination could seriously jeopardize the life or health of the **claimant**; or jeopardize the ability of the **claimant** to regain maximum function; or in the opinion of a **physician** with knowledge of the **claimant's** medical condition, would subject the **claimant** to severe pain that could not be adequately managed without the care or treatment that is the subject of the claim and the plan conditions receipt of the benefit for the service, in whole or in part, on approval in advance of obtaining medical care.

A **health care professional** with knowledge of the **claimant's** medical condition may determine if a claim is one involving urgent care. If there is no such **health care professional**, an individual acting on behalf of the plan, applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine, may make the determination.

- This plan does not condition benefit payment whether an urgent care claim or a non-urgent care claim, on any advance notification. Plan inquiries regarding benefits will be responded to as a courtesy and are not a guarantee of payment. Inquiries may be made in writing to the **Plan Supervisor**, NGS, P.O. Box 7676, St. Clair Shores, MI 48080, or by calling (800) 521-1555.

Prosthetic device: an artificial part affixed to the body. Most often this attachment is performed during a period of hospitalization, through **surgery** to remedy a deficiency or defect of the body.

Psychiatrist: a licensed Doctor of Medicine (MD) or Doctor of Osteopathy (DO) who specializes in the study and treatment of **mental disorders** and psychological diseases.

Psychologist: a licensed individual who is usually a Ph.D. and is trained in methods of psychological analysis, therapy and research for treatment of psychological and psychoneurological disorders.

Reliable scientific evidence:

- Peer reviewed scientific studies published in or accepted for publication by medical journals that meet nationally recognized requirements for scientific manuscripts and that submit most of their published articles for review by experts who are not part of the editorial staff; or
- Peer reviewed literature, biomedical compendia, and other medical literature that meet the criteria of the National Institute of Health's National Library of Medicine for indexing in index Medicus, Excerpta Medicus (EMBASE), Medline, NCCN, or Medlars database Health Services Technology Assessment Research (STAR).

Regional PPO network: a network with which Port Huron Hospital has a contract.

Skilled nursing facility: a facility approved by **Medicare**, which is primarily engaged in providing 24-hour skilled nursing and related services on an **inpatient** basis to patients requiring convalescent and rehabilitative care. Such care is rendered by or under the supervision of **physicians**. A **skilled nursing facility** is not, other than incidentally, a place that provides:

- minimal care, **custodial care**, ambulatory care or part-time care services; or
- care or treatment of **mental disorders**, substance abuse, alcoholism, drug abuse or pulmonary tuberculosis.

Speech therapist: a **health care professional** licensed, accredited, registered or certified to perform speech therapy consistent with state law.

Standby physician: a **physician** who is present in the event a complication occurs at the time a surgical procedure is performed, but who is not actually assisting the attending **physician** with the **surgery**.

Summary Plan Description (SPD): this summary of your benefits.

Surgery: a cutting operation, suturing of a wound, treatment of a fracture, relocation of a dislocation, radiotherapy (if used in lieu of a cutting operation), diagnostic and therapeutic endoscopic procedures, laser **surgery**, and injections classified as **surgery** under the CPT.

Surrogate mother: a woman who bears a child for another person, often for pay, either through artificial insemination or by carrying until birth another woman's surgically implanted fertilized egg.

Totally disabled: an **individual** is **totally disabled** when he or she is prevented because of **injury** or disease from engaging in substantially all of the normal activities of a person of like age and sex in good health.

In any case where the **Plan Administrator** (or **Plan Supervisor** at the request of the **Plan Administrator**) is required to make a determination as to whether an individual is **totally disabled**, the **Plan Administrator** or **Plan Supervisor** shall have the right to require the individual to submit to an examination by a **physician** or medical clinic selected by the **Plan Administrator** or **Plan Supervisor**.

Weekend admissions: any admission for scheduled, non-emergency **surgery**, where the admission is on Friday or Saturday and, at the time of admission, the **surgery** is scheduled to be performed the following week.

COBRA CONTINUATION COVERAGE

What Is COBRA?

The right to **COBRA** continuation coverage was created by a federal law, the **Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)**. **COBRA** continuation coverage can become available to you and to other members of your family who are covered under the plan when you would otherwise lose your group health coverage.

When Would I Qualify For COBRA?

Continuation coverage is available if coverage would otherwise end due to:

- termination of your employment for reasons other than gross misconduct; or
- reduction in your work hours; or
- for your **dependent** spouse – divorce or legal separation from you; or
- for your **dependent** spouse or child(ren) – your death; or
- for your **dependent** child(ren), loss of eligibility as a covered **dependent** (e.g., because he or she reaches the maximum age provided by the plan); or
- for a retiree, if the former employer files for bankruptcy under Chapter 11.

Specific information regarding your rights under **COBRA** is available in the Port Huron Hospital Comprehensive Welfare Plan. Please refer to that document for a complete description.

What Other Facts Should I Know Regarding My Rights Under COBRA?

In order to protect your family's rights, you should keep your employer informed of any changes in the addresses of family members who are or may become eligible for **COBRA**. You should also keep a copy of any notices you send the **Plan Administrator** for your records.

Who Should I Contact For Further Information And To Whom Should I Provide Notice Of COBRA Events?

If you need more information regarding continuation of coverage, please feel free to contact NGS or contact the **Plan Administrator**. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Address and phone numbers of Regional and District EBSA Offices are available through EBSA's website at www.dol.gov/ebsa.

The **Corporation** is responsible for administering **COBRA** continuation. These functions may include mailing of **COBRA** notices, collection of premium payments and reporting of paid participants to applicable vendors.

The **Corporation** is responsible for administering **COBRA** continuation. The **Corporation** has contracted with to perform certain administrative functions on its behalf. These functions may include mailing of **COBRA** notices, collection of premium payments and reporting of paid participants to applicable vendors.

HIPAA PRIVACY RULES

The HIPAA Privacy Rules refers to those provisions of the Health Insurance Portability and Accountability Act of 1996 that relate to the safe handling of Protected Health Information and the regulations issued thereunder in 45 CFR Parts 160 and 164.

Protected Health Information (PHI)

PHI includes information that the plan creates or receives that relates to the past, present, or future health or medical condition of an individual that could be used to identify the individual.

Use And Disclosure Of PHI

The plan can use or disclose PHI for purposes of Payment and Health Care Operations. Payment means activities to obtain and provide reimbursement for the health care provided to an individual, including determinations of eligibility and coverage under the plan, and other health care utilization review activities.

Health Care Operations means the support functions related to treatment and payment, such as quality assurance activities, case management, receiving and responding to patient complaints, **physician** reviews, compliance programs, audits, business planning, development, management, and administrative activities.

Your Rights Under HIPAA

Each individual covered under the plan ("the individual") is entitled to certain rights and protections. An individual has the right to request Access to PHI, request an Amendment to PHI, request an Accounting of PHI disclosures and request a Restriction in the handling of your PHI as set forth below.

If an individual requests Access, Amending, Accounting or Restriction of PHI for someone for whom they do not have the right, such as a spouse requesting an Accounting of PHI for the **employee** or the **employee** requesting an Accounting of PHI for a **dependent** over age 18, he/she must present a completed Personal Representative Affidavit or another legal document granting him/her authority.

For specific and detailed information regarding your rights under HIPAA and the **Corporation's** HIPAA policy, please refer to the Port Huron Hospital Comprehensive Welfare Plan.

Separation Of Plan And Plan Sponsor

The Plan Sponsor has provided a certification that requires assurance that the Plan Sponsor will appropriately safeguard and limit the use and disclosure of PHI that the Plan Sponsor may receive from the plan to perform plan Administration Functions. Specifically, Plan Sponsor has agreed:

- not to use or further disclose PHI other than as permitted or required by the **Plan Document** or as required by law;
- to 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 Sponsor with respect to such information;
- not to use or disclose PHI for employment related actions and decisions or in connection with any other benefit or employee benefit plan;
- to report to the plan any use or disclosure of the PHI that is inconsistent with the uses or disclosures permitted by the HIPAA Rule of which it becomes aware;
- to make available information in accordance with the HIPAA Rules regarding individual access to PHI;
- to make available PHI for amendment in accordance with the HIPAA Rules;
- to make available the information required under the HIPAA Rules to provide an accounting of non-routine disclosures to the individual;
- to make internal practices, books, and records relating to PHI available to the Department of Health and Human Services for purposes of determining compliance as required by the HIPAA Rules;
- to, if feasible, return or destroy all PHI received from the plan that Plan Sponsor 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 the separation of the plan and Sponsor.

Permitted **employees** may also use the PHI for plan Administrative Functions that Plan Sponsor performs for the plan such as:

- Summary Health Information for the purpose of obtaining premium bids, including bids in connection with the placement of stop loss coverage;
- Summary Health Information for use in making decisions to modify, amend or terminate the plan.

Plan Administrative Functions means administrative functions performed on behalf of the plan and excludes functions performed by the Plan Sponsor in connection with any other benefit or benefit plan of the Plan Sponsor.

Any controversy or claim arising out of or relating to a violation of any of the separation and/or disclosure provisions agreed to in the certification and described in this notice may be reported to:

Compliance Officer
Port Huron Hospital Medical Benefits Plan
1221 Pine Grove Avenue
Port Huron, MI 48060
(810) 989-3708

Privacy Policy Changes

The plan may change the privacy policies from time to time to comply with the understanding of applicable laws and to provide the best service possible under the plan. Any change in policy will be made available to plan participants.

For questions about the plan's policies or to file a complaint, an Individual may call or write the Health Plan's Privacy Official at the following address:

Compliance Officer
Port Huron Hospital Medical Benefits Plan
1221 Pine Grove Avenue
Port Huron, MI 48060
(810) 989-3708

If an individual wishes to exercise their rights to request access or amend PHI, or receive an accounting of disclosures or a restriction on use or disclosure of PHI, the individual may contact the plan's Privacy Official or the organization listed below:

NGS
27575 Harper Avenue
St. Clair Shores, MI 48081
(800) 521-1555

HELP FIGHT FRAUD

Combating fraud and abuse takes a cooperative effort from each of us. One way for you to help is by reviewing your Explanation of Benefits (EOB) to be sure that the services billed to us were reported properly. If you should see a service and/or supply billed to us that you did not receive, please report that immediately in writing. Indicate in your letter that you are filing a potential fraud complaint and document the following facts:

- The name and address of the provider,
- The name of the beneficiary who was listed as receiving the service or item,
- The claim number,
- The date of the service in question,
- The service or item that you do not believe was provided,
- The reason why you believe the claim should not have been paid, and
- Any additional information or facts showing that the claim should not have been paid.

Detection Tips

You should be suspicious of practices that involve:

- Providers who routinely do not collect your cost share (co-payment).
- Billing by your provider for services that you did not receive.
- Providers billing for services or supplies that are different from what you received.

Prevention Tips

- Always protect your NGS identification card. Know to whom you are giving your Member ID Number. Do not provide your member number to someone over the phone if they call you.
- Be skeptical of providers who tell you that a particular item or service is not usually covered by us, but knows how to bill for the item or service to get it paid.

Who Do I Contact If I Suspect Fraud, Waste Or Abuse?

Mail: NGS
P.O. Box 7676
St. Clair Shores, MI 48080

Phone: (800) 521-1555

HOW TO FILE MEDICAL CLAIMS

A General Overview

A claim is defined as any request for a plan benefit made by a **claimant** that complies with the plan's reasonable procedure for making benefit claims.

There are different types of claims. Reasonable claim filing procedures, which are different for each type of claim, are described below. Each type of claim has a specific timetable for approval, payment, request for further information, denial of the claim and for review of any **adverse benefit determination**.

The times listed below for response and appeals are maximum times only. A period of time begins at the time the claim is received, as explained in the claim filing procedures for each type of claim. Decisions will be made within a reasonable period of time appropriate to the circumstances. Throughout this section, "days" means calendar days.

What Should You Know About Pre-Service Claims?

Whenever the plan requires advance approval of a service or treatment, the purpose of a **pre-service claim** is to provide the **claimant** with a determination of whether or not the approval process will prevent payment of the claim and to give you the opportunity to appeal any **adverse benefit determination** made during the pre-approval process. However, the claim determination made on a **pre-service claim** review does not guarantee payment of any **post-service claim**.

Plan Procedures For Filing A Pre-Service Care Claim

A **claimant** may file a **pre-service claim** by telephone, mail or electronic media. The plan may have specific requirements associated with notification of **pre-service claims**.

The following information should be provided to the **Claims Administrator** for **pre-service claims**.

- The **employee's** name, name of the employer and four-digit division code; this information is embossed on your NGS identification card.
- The **employee's** unique identification number.
- The name of the patient and relationship to the **employee**.
- The proposed date of service.
- The **diagnosis** and type of service to be provided.

The **Claims Administrator** must reply to the claim request within a certain time period. The **claimant** must also respond to any request from the **Claims Administrator** within certain time periods. Those time periods are described below.

Urgent Care Pre-Service Claims

If an urgent care **pre-service claim** is filed following the proper claims filing procedures, and no additional information is needed, the **Claims Administrator** will notify the **claimant** of a decision within 72 hours.

If additional information is needed the **Claims Administrator** will notify the **claimant** within 24 hours. The **claimant** will have up to 48 hours from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 48 hours after the request for information.

When proper claims filing procedures are not followed, the **Claims Administrator** must notify the **claimant**, orally or in writing, within 24 hours of receipt of the claim. The **claimant** must respond to that notification within 72 hours. If the **claimant** does not properly file the claim within 72 hours, the claim will be denied. If the **claimant** properly files the claim within 72 hours, the **Claims Administrator** will notify the **claimant** of a decision within 48 hours of receipt of the properly filed claim.

If an **adverse benefit determination** is given, the **claimant** may appeal the decision. Refer to the section titled "Adverse Benefit Determinations and Appeals" for further information.

Non-Urgent Care Pre-Service Claims

If a non-urgent **pre-service claim** is filed following the proper claims filing procedures and no additional information is needed, the **Claims Administrator** will notify the **claimant** of a decision within 15 days.

If additional information is needed, or there are matters that prevent a decision and they are beyond the control of the plan, the **Claims Administrator** will notify the **claimant** within 15 days. The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of your response. If the **claimant** does not respond to the request for information, the claim will be denied within 60 days after the request for information. Should the required information be submitted subsequently, the claim will be considered a new request and will be reviewed in accordance with the above guidelines, if filed within the claim filing timeframe (refer to the section titled "What Is Not Covered?")

When proper claims filing procedures are not followed, the **Claims Administrator** must notify the **claimant**, orally or in writing, within 5 days of receipt of the claim. The **claimant** must respond to that notification within 15 days. If the **claimant** does not properly file the claim within these 15 days, the claim will be denied.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. Please see the section titled "Adverse Benefit Determinations and Appeals" for further information.

What Should You Know About Post-Service Claims?

Plan Procedures For Filing A Post-Service Claim

The **claimant** may file a **post-service claim** by mail or electronic media directly with the **Claims Administrator**. The plan does not require the filing of a claim form. When a provider files a claim, they will be considered the **authorized representative** of the patient.

For medical **post-service claims**, your **Claims Administrator** is NGS, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

The **Claims Administrator** for pharmacy **post-service claims** is Port Huron Hospital, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108.

Original bills and/or receipts with the complete claims information listed below should be sent to NGS. In the case of a bill from a **network provider** where the Network requires claims be submitted through them, the bill will not be considered a claim until it is received by the Network. In addition to bills filed by hard copy, NGS will consider claims filed electronically as original claims.

Required Information

When submitting a medical claim, the following information must be presented:

- The **employee's** name, name of the employer and four-digit division code; this information is embossed on your NGS identification card.
- The **employee's** unique identification number.
- The name of the patient and relationship to the **employee**.
- The date of service.
- The provider's name and degree.
- The medical condition for which treatment was provided.
- The charge for each specific service.

Unless you submit proof that you have paid for the services billed, payment will be made to the provider as your **authorized representative**.

This plan intends, through NGS, to promptly acknowledge and make a claims determination on claims submitted. In order to do this, the plan needs your cooperation. In most cases when a bill is sent to NGS directly by the provider, the claims information listed above will be on the bill. If you send a bill or receipt to NGS, you should be sure the above claim information is given.

Prescription drugs purchased in a pharmacy are covered by the separate **prescription drug** benefit administered by Port Huron Hospital. Please refer to the section titled "What If I Need a Prescription Medication?" for additional information.

Providing Additional Information

Additional information provided at the time of the claim will help in making a determination. For example, if the bill is for your covered **dependent** that has other medical coverage, send a copy of the other coverage's proof of payment or denial.

If the bill is for services rendered due to an accidental bodily **injury**, please provide the following details:

- How the accident happened?
- When the accident happened?
- The name and address of anyone who was responsible for the **injury**.

Time Periods For The Plan And You

The **Claims Administrator** must reply to a claim request within a certain time period. The **claimant** must also respond to the request for additional information from the **Claims Administrator** within certain time periods.

When a **post-service claim** is filed, and all information needed to make a claim determination is present, the **Claims Administrator** must notify the **claimant** of a claims decision within 30 days from the date the claim is received.

If a **post-service claim** is filed and additional information is needed, the **Claims Administrator** must notify the **claimant** within 30 days.

The **claimant** will have up to 45 days from the request to supply the needed information. When the information is received, the **Claims Administrator** will notify the **claimant** of a decision within 15 days from the receipt of the response. If the **claimant** does not respond to the request for information, the claim will be denied within 60 days after the request for information. Should the required information be submitted subsequently, the claim will be considered a new request and will be reviewed in accordance with the above guidelines, if filed within the claim filing timeframe. See the section titled "What Is Not Covered?" for additional information regarding the claims filing timeframe.

If an **adverse benefit determination** is given, the **claimant** may appeal that decision. Please see the section titled "Adverse Benefit Determinations and Appeals" for further information.

ADVERSE BENEFIT DETERMINATIONS AND APPEALS

What If My Claim Is Denied?

Except with Urgent Care Claims, when the notification may be given orally followed by written or electronic notification within three days of the oral notification, the **Claims Administrator** shall provide written or electronic notification of any **adverse benefit determination**. The notice will state, in a manner calculated to be understood by the **claimant**:

1. The specific reason or reasons for the **adverse benefit determination**.
2. Reference to the specific plan provisions on which the determination was based.
3. A description of any additional material or information necessary for the **claimant** to perfect the claim and an explanation of why such material or information is necessary.
4. A description of the plan's review procedures and the time limits applicable to such procedures. This will include a statement of the **claimant's** right to bring a civil action under section 502 of ERISA following an **adverse benefit determination** on review.
5. A statement that the **claimant** is entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim.
6. If the **adverse benefit determination** was based on an internal rule, guideline, protocol, or other similar criterion, the specific rule, guideline, protocol, or criterion which was relied on will be provided free of charge to the **claimant** upon request.
7. If the **adverse benefit determination** is based on medical necessity or **experimental** or **investigational** treatment or a similar exclusion or limitation, an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to the **claimant's** medical circumstances, will be provided free of charge to the **claimant** upon request.

How Do I File An Appeal?

If a **claimant** receives an **adverse benefit determination** for an urgent **pre-service claim**, the **claimant** may appeal that decision in writing, via mail, facsimile, or electronically. The **claimant** may submit written comments, documents, records, and other information relating to the claim. The appeal and all supporting documentation should be submitted to the **Claims Administrator**, who will provide a decision regarding the appeal within 72 hours.

If a **claimant** receives an **adverse benefit determination** for a non-urgent **pre-service claim**, the **claimant** may appeal the decision within 180 days of date of the **adverse benefit determination**. The **claimant** may submit written comments, documents, records, and other information relating to the claim. If the **claimant** requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The **Claims Administrator** will review the appeal and respond within 30 days.

If a **claimant** receives an **adverse benefit determination** for a **post-service claim**, the **claimant** may appeal the decision within 180 days of date of the **adverse benefit determination**. The **claimant** may submit written comments, documents, records, and other information relating to the claim. If the **claimant** requests, he/she will be provided, free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to the claim. The **Claims Administrator** will review the appeal and respond within 60 days.

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

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

1. was relied upon in making the benefit determination;
2. was submitted, considered, or generated in the course of making the benefit determination, without regard to whether it was relied upon in making the benefit determination;
3. demonstrated compliance with the administrative processes and safeguards designed to ensure and to verify that benefit determinations are made in accordance with **Plan Documents** and plan provisions have been applied consistently with respect to all **claimants**; or
4. constituted a statement of policy or guidance with respect to the plan concerning the denied treatment option or benefit.

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

If the determination was based on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is **experimental, investigational**, or not **medically necessary** or appropriate, the **Claims Administrator** will consult with a **health care professional** who was not involved in the original benefit determination. This **health care professional** will have appropriate training and experience in the field of medicine involved in the medical judgment. Additionally, medical or vocational experts whose advice was obtained on behalf of the plan in connection with a review on appeal will be identified.

Is The Decision On Review Final?

The decision by the **Claims Administrator** on review will be final, binding, and conclusive, and will be afforded the maximum deference permitted by law. **All claim review procedures provided for in the plan must be exhausted before any legal action is brought.**

FACILITY OF PAYMENT

Whenever payments which should have been made under this plan in accordance with its provisions have been made under any other plans, the plan shall have the right, exercisable alone and in its full discretion, to pay over to any organizations making such other payments any amounts it shall deem to be warranted in order to satisfy the intent of this coordination provision. Any amount so paid shall be deemed to be benefits paid under this plan and to the extent of such payments; the plan shall be fully discharged from liability.

Plan payments will be made to the provider whenever there is no evidence showing that the provider has been paid. If the provider has been paid and the **employee** authorizes payment to another individual, the plan will pay that individual upon receipt of the **employee's** signed authorization.

If an **employee** dies, the plan will determine payment of claims as follows:

- First, to any providers who have not received payment that would be due under the plan;
- Second, the **employee's** spouse;
- Third, the **employee's** estate.

REIMBURSEMENT OF PLAN PAYMENTS

The plan is designed to only pay covered expenses for which payment is not available from anyone else, including any insurance company or another health plan. In order to help you or your covered **dependents** in a time of need, however, the plan may pay covered expenses that may be or may become the responsibility of another person, provided that the plan later receives reimbursement for those payments (hereinafter called "Reimbursable Payments").

Therefore, by enrolling in the plan, as well as by applying for payment of covered expenses, you and your covered **dependents** are subject to, and agree to, the following terms and conditions with respect to the amount of covered expenses paid by the plan:

1. Assignment of Rights (Subrogation). You and your covered **dependents** automatically assign to the plan any rights the covered person may have to recover all or part of the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. This assignment includes, without limitation, the assignment of a right to any funds paid by a third party to a covered person or paid to another for the benefit of the covered person. This assignment applies on a first-dollar basis (i.e., has priority over other rights), applies whether the funds paid to (or for the benefit of) the covered person constitute a full or a partial recovery, and even applies to funds paid for non-medical or **dental** charges, attorney fees, or other costs and expenses. This assignment also allows the plan to pursue any claim that the covered person may have, whether or not the covered person chooses to pursue that claim. By this assignment, the plan's right to recover from insurers includes, without limitation, such recovery rights against no-fault auto insurance carriers in a situation where no third party may be liable, and from any uninsured or underinsured motorist coverage.

2. Equitable Lien and other Equitable Remedies. The plan shall have an equitable lien against any rights you or your covered **dependent** may have to recover the same covered expenses from any party, including an insurer or another group health program, but limited to the amount of Reimbursable Payments made by the plan. The equitable lien also attaches to any right to payment 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 or the employer will be deemed to mean that such a determination has been made.

This equitable lien shall also attach to any money or property that is obtained by anybody (including, but not limited to, the covered person, the covered person's attorney, and/or a trust) as a result of an exercise of the covered person's rights of recovery (sometimes referred to as "proceeds"). The plan shall also be entitled to seek any other equitable remedy against any party possessing or controlling such proceeds. At the discretion of the **Plan Administrator**, the plan may reduce any future covered expenses otherwise available to the covered person under the plan by an amount up to the total amount of Reimbursable Payments made by the plan that is subject to the equitable lien.

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 that were enunciated in the United States Supreme Court's decision entitled, Great-West Life & Annuity Insurance Co. v. Knudson, 534 US 204 (2002); and Sereboff v. Mid Atlantic Medical Services, Inc (MAMSI), 126 S.Ct. 1869, 547 US 356 (2006). The provisions of the plan concerning subrogation, equitable liens and other equitable remedies are also intended to supersede the applicability of the federal common law doctrines commonly referred to as the "make whole" rule and the "common fund" rule.

3. Assisting in Plan's Reimbursement Activities. You and your covered **dependents** have an obligation to assist the plan to obtain reimbursement of the Reimbursable Payments that it has made on behalf of the covered person, and to provide the plan with any information concerning the covered person's other insurance coverage (whether through automobile insurance, other group health program, or otherwise) and any other person or entity (including their insurer(s)) that may be obligated to provide payments or benefits to or for the benefit of the covered person. The covered person is required to (a) cooperate fully in the plan's exercise of its right to subrogation and reimbursement, (b) not do anything to prejudice those rights (such as settling a claim against another party without including the plan as a co-payee for the amount of the Reimbursable Payments and notifying the plan), (c) sign any document deemed by the **Plan Administrator** to be relevant to protecting the plan's subrogation, reimbursement or other rights, and (d) provide relevant information when requested. The term "information" includes any documents, insurance policies, police reports, or any reasonable request by the **Plan Administrator** to enforce the plan's rights.
4. Overpayments. This plan will have the right to recover any payments that were made to, or on behalf of, a **covered individual** and which causes an overpayment to be made.

Failure by you or your covered **dependents** to follow the above terms and conditions may result, at the discretion of the **Plan Administrator**, in a reduction from future benefit payments available to the covered person under the plan of an amount up to the aggregate amount of Reimbursable Payments that has not been reimbursed to the plan.

GENERAL PLAN INFORMATION

Plan Name

The name of the plan is Port Huron Hospital Medical Benefits Plan as Amended and Restated effective January 1, 2010.

Type Of Plan

This plan is a welfare benefits plan providing medical benefits.

Plan Number

The plan number is 510.

Plan Administrator And Named Fiduciary

The **Plan Administrator** and named fiduciary is Port Huron Hospital, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108, or its successor in the event of a merger or acquisition by another organization or corporation.

Employer Identification Number

The employer identification number is 38-1369611.

Cost Of The Plan

Port Huron Hospital pays most of the cost of providing benefits to you and your **dependents**. However, you are responsible for your portion of the cost, as well as for the full premium costs for **dependents** age 19 to 25 who are college students.

Plan Effective Date

The original plan effective date was September 1, 1994. The plan has been amended and restated effective January 1, 2010.

Plan Distribution Date

The plan is effective as stated above. However, until the plan distribution date, the greatest of the benefits provided by this plan or the benefits provided under the prior plan sponsored by the employer will apply to any claims by a **covered individual**.

Plan Year

The fiscal year of this plan commences on the first day of January and ends on the last day of the following December.

Plan Supervisor

The **Plan Supervisor** is NGS, 27575 Harper, P.O. Box 7676, St. Clair Shores, MI 48080, (800) 521-1555.

Plan Is Not A Contract Of Employment

The plan shall not be deemed to constitute an employment contract between Port Huron Hospital and the **employee** or to be a consideration for, or an inducement or condition of, the employment of any **employee**. Nothing in the plan shall be deemed to give any **employee** the right to be retained in the service of the **Corporation** or to interfere with the right of the **Corporation** to terminate any **employee** at any time. Nor do these documents change any such employment relationship to be other than employment "at will."

YOUR RIGHTS UNDER ERISA

What Are My Rights Under ERISA?

As a participant in the plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA specifically states that all plan participants shall be entitled to the following rights.

- the right to receive information about the plan
- the right to continue group health plan coverage
- the right to obtain certificates of **creditable coverage** and the effect of the certificate
- the right to enforce your rights
- the right to receive assistance with your questions

For detailed and specific information regarding your rights under ERISA, please refer to the Port Huron Hospital Comprehensive Welfare Plan.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Who Are The Fiduciaries Of The Plan?

Port Huron Hospital is the **Plan Administrator** and named fiduciary within the meaning of Section 402(a) (1) of ERISA for everything not delegated to another fiduciary in this document. Port Huron Hospital shall exercise all discretionary authority and control with respect to management of the plan, unless authority and control have been specifically granted to another fiduciary.

Port Huron Hospital may delegate certain fiduciary responsibilities under the plan to persons who are not named fiduciaries of the plan. If fiduciary responsibilities are delegated to any other person, except as otherwise required by ERISA, such delegation of responsibility should be made by written instrument executed by Port Huron Hospital. A copy of the written instrument delegating the responsibility will be kept with the records of the plan.

NGS has, by written instrument, been designated as the Fiduciary for Final Claims Determination for medical **post-service claims** submitted to the plan. By making this designation, it is the Plan Sponsor's intention that NGS make final claim determinations and have final discretion in construing the terms of the plan with respect to final claim determinations. NGS shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

What Are The Fiduciaries' Responsibilities?

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries.

Each fiduciary under the plan shall be solely responsible for its own acts or omissions. Except to the extent required by ERISA, no fiduciary shall have the duty to question whether any other fiduciary is fulfilling all of the responsibilities imposed upon such other fiduciary by federal or state law. No fiduciary shall have any liability for a breach of fiduciary responsibility of another fiduciary with respect to the plan unless it participates knowingly in such breach, knowingly undertakes to conceal such breach, has actual knowledge of such breach, fails to take responsible remedial action to remedy such breach or, through its negligence in performing its own specific fiduciary responsibilities which give rise to its status as a fiduciary, it enables such other fiduciary to commit a breach of the latter's fiduciary responsibility.

No fiduciary shall be liable with respect to a breach of fiduciary duty if such breach is committed before it became a fiduciary, and nothing in this plan shall be deemed to relieve any person from liability for his or her own misconduct or fraud.

What If The Plan Is Modified, Amended Or Terminated?

Port Huron Hospital, by a duly **authorized representative**, may modify, amend, or terminate the plan at any time at its sole discretion.

Any such modification, amendments, or terminations that affect plan participants or beneficiaries of the plan will be communicated to them. If the plan is terminated, benefits will only be paid for claims incurred before the date of termination up to the time funds are no longer available.

Who Is Responsible For The Administration Of The Plan?

Port Huron Hospital is the **Plan Administrator**. As **Plan Administrator**, Port Huron Hospital is required to supply you with this booklet and other information, and to file various reports and documents with government agencies. In its role of administering the plan, the **Plan Administrator** also may make rulings, interpret the plan, prescribe procedures, gather needed information, receive and review financial information of the plan, employ or appoint individuals to assist in any administrative function, and generally do all other things which need to be handled in administering the plan.

The **Plan Administrator** shall have any and all powers of authority, except as otherwise delegated in this document, which shall be proper to enable him/her to carry out his/her duties under the plan. Examples of such powers and authority are as follows: (i) the powers and authority contemplated by the Employee Retirement Income Security Act of 1974 ("ERISA") with respect to employee welfare plans, and (ii) the powers of authority to make regulations with respect to the plan that are consistent with the plan or ERISA, and to determine, consistently therewith, all questions that may arise as to the status and rights of participants and beneficiaries and any and all other persons.

The **Plan Administrator** will determine eligibility for benefits under the plan. The **Plan Administrator** has delegated fiduciary responsibility for medical **post-service claim** decisions to: NGS. The plan shall be governed by and interpreted according to ERISA and the Internal Revenue Code and, where not preempted by Federal law, the laws of the state of Michigan.

In exercising its authority under this plan, the **Plan Administrator** or any fiduciary to whom authority has been granted under this plan, shall have full and absolute discretion, and any decisions of the **Plan Administrator** or other fiduciary may not be overturned in a subsequent judicial or administrative proceeding unless found to be arbitrary and capricious.

How Is The Plan Funded?

The plan is funded through the general assets of Port Huron Hospital, and contributions as required. In the event of plan termination, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. If the plan should be terminated, claims incurred prior to the date of such termination would be paid until the time funds are no longer available. Claims incurred after the date of such termination would not be paid.

Is This Plan Considered Health Insurance?

Under Michigan law, the **Plan Supervisor** is required to disclose the following information.

The Port Huron Hospital Medical Benefits Plan is a self-funded plan. You and your covered **dependents** are not insured. In the event this plan does not ultimately pay medical expenses that are eligible for payment under this plan for any reason, you or your covered **dependents** may be liable for those expenses.

The medical **Claims Administrator**, NGS, merely processes claims and does not insure that any medical expenses of individuals covered by this plan will be paid.

When you or your covered **dependent** file complete and proper claims for benefits, those claims will be promptly processed. In the event of a delay in processing, the you or your covered **dependent** shall have no greater right or interest or other remedy against the medical **Claims Administrator**, NGS, than as otherwise afforded by law.