

**SUMMARY PLAN DESCRIPTION OF
PORT HURON HOSPITAL
VISION BENEFITS PLAN
EFFECTIVE JANUARY 1, 2002**



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INTRODUCTION

Your benefits plan is intended to help you with the expense you, or any covered family member, may incur due to an **Illness** or **Injury** which is not work related.

This booklet or **Summary Plan Description** includes information describing your plan benefits, first in general, and then specifically, including how each type of service is covered by this plan. Specific services that are not covered are listed in the section of this booklet titled WHAT IS NOT COVERED BY THIS PLAN?

You will notice that certain words in this **Summary Plan Description** have been capitalized. These words have a special meaning in this plan and are defined in the section titled WHAT IS MEANT BY...? in this booklet.

Your benefits plan is governed by a legal document referred to as the **Plan Document**. This booklet, referred to as a **Summary Plan Description**, is written in a manner meant to be easily understood as an explanation of the benefits provided for you in the **Plan Document**.

Port Huron Hospital reserves the right, at any time and from time to time, to modify, amend or terminate the plan, in whole or in part, with respect to all or any class of **Employees**. Any such amendment to the plan shall be expressed in an instrument executed by an authorized officer of the **Corporation**, and shall become effective as of the date designated in such instrument.

The plan is intended to comply with all provisions of the Americans with Disabilities Act (ADA), the Family and Medical Leave Act (FMLA) and the Health Insurance Portability and Accountability Act (HIPAA). Any provision of this plan found to be in conflict with these acts is amended to comply with these acts.

You will find information on the following pages which describes your benefits. If you have any questions, please contact Human Resources.

GENERAL PLAN INFORMATION

PLAN NAME

The name of the plan is Port Huron Hospital Vision Benefits Plan as Amended and Restated January 1, 2002.

TYPE OF PLAN

The plan is a welfare benefits plan providing vision benefits.

PLAN NUMBER

The plan number is 505.

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 plan identification number is 38-1369611.

COST OF THE PLAN

Active full-time and active part-time **Employees** pay the full cost of providing vision benefits for themselves and their **Dependents**.

PLAN EFFECTIVE DATE

The original **Plan Effective Date** is September 1, 1994. The plan has been amended and restated effective January 1, 2002.

PLAN DISTRIBUTION DATE

The plan is effective as stated above. However, until the plan distribution date of July 2002, 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 the plan commences on the first day of January ends on the last day of the following December.

PLAN SUPERVISOR

The **Plan Supervisor** is NGS American, Inc., 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.

YOUR RIGHTS UNDER ERISA

Port Huron Hospital fully intends to administer this Vision Benefits Plan on a fair basis, while giving you all the rights you are entitled to 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 provides that all plan participants shall be entitled to:

- Examine, without charge, at the **Plan Administrator's** office, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the **Plan Administrator**, copies of documents governing the operation of the plan, including insurance contracts and copies of the latest annual report (Form 5500 Series) and updated **Summary Plan Description**. The administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The **Plan Administrator** is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for yourself, your spouse or **Dependents** if there is a loss of coverage under the plan as a result of a qualifying event. You or your **Dependents** may have to pay for such coverage. Review this **Summary Plan Description** and the documents governing the plan on the rules governing your **COBRA** continuation coverage rights.

YOUR RIGHTS UNDER ERISA (Continued)

- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health insurance issuer when you lose coverage under the plan, when you become entitled to elect **COBRA** continuation coverage, when your **COBRA** continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a pre-existing condition exclusion. See the section titled PRE-EXISTING CONDITION LIMITATION for more information.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the **Employee** benefit plan. The people who operate your plan, called “fiduciaries” of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the **Plan Administrator** review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the **Plan Administrator** to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan’s decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan’s money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the **Plan Administrator**. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, NW, Washington, DC 20210.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Port Huron Hospital is the named fiduciary with respect to this plan within the meaning of Section 402(a)(1) of ERISA, solely to the extent of its responsibilities specified in the plan and service agreement. Port Huron Hospital shall exercise all discretionary authority and control with respect to management of the plan which is not specifically granted to the **Plan Supervisor**, NGS American, Inc., or another fiduciary.

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.

Port Huron Hospital may delegate certain of its fiduciary responsibilities under this 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 shall be made by written instrument executed by Port Huron Hospital, a copy of which will be kept with the records of the plan.

PLAN MODIFICATION, AMENDMENT AND TERMINATION

Port Huron Hospital reserves the right, at any time and from time to time, to modify, amend or terminate the plan, in whole or in part, with respect to all or any class of **Employees**. Any such amendment to the plan shall be expressed in an instrument executed by an authorized officer of the **Corporation**, and shall become effective as of the date designated in such instrument. Any such amendment, modification or termination of the plan in whole or in part shall be reflected in action taken by the Board of Directors of the **Corporation** (or by action of an officer or officers of the **Corporation** to whom the Board of Directors has delegated the authority to modify or amend the provisions of the plan or to terminate the plan in whole or in part).

Coverage under this benefit program, or receipt of any benefit from the plan, does not in any way affect your employment relationship with the **Corporation** or your employer, or in any way limit the **Corporation** or your employer's right to terminate your employment.

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 which shall be proper to enable him to carry out his duties under the plan, including by way of illustration and not limitation (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 not inconsistent 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** shall have full discretionary authority to interpret all provisions of this plan, including resolving an inconsistency or ambiguity or correcting an error or an omission. 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.

PLAN FUNDING AND ASSET DISTRIBUTION UPON TERMINATION

This plan is funded through the general assets of Port Huron Hospital and contributions as required. If the plan should be terminated, only claims incurred prior to the date of such termination would be eligible for payment by this plan, provided funds are available at that time. However, there are no specific assets set aside to use to pay claims incurred prior to the date of such termination. In the event that no assets or funds are available upon termination of this plan, the individuals covered by this plan may be liable for those expenses.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

Port Huron Hospital Employee Vision Benefits Plan as Amended and Restated January 1, 2002 is a self-funded plan. **Covered Individuals** in this plan are not insured. In the event this plan does not ultimately pay vision expenses that are eligible for payment under this plan for any reason, the individual covered by this plan may be liable for those expenses.

The **Plan Supervisor**, NGS American, Inc., merely processes claims and does not insure that any vision expenses of individuals covered by this plan will be paid.

Complete and proper claims for benefits made by **Covered Individuals** will be promptly processed. In the event of a delay in processing, the **Covered Individual** shall have no greater right or interest or other remedy against the **Plan Supervisor**, NGS American, Inc., than as otherwise afforded by law.

ELIGIBILITY

WHO IS ELIGIBLE FOR BENEFITS?

You are eligible for enrollment 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 and are a participant in the flexible benefits plan - please refer to the Employee Handbook for further details).

When you are eligible and enroll in this plan, the following **Dependents** may enroll for coverage:

- Your lawful spouse.
- Your unmarried natural children, step-children, legally adopted children, children under court appointed legal guardianship, and children for whom you are under court order to provide medical care. Those children will be eligible until the end of the month in which they reach their 19th birthday.
- A **Dependent** child who is disabled by mental or physical incapacity before they are 19 years of age. That child will be eligible for enrollment in this plan only if that **Dependent** child was enrolled prior to their 19th birthday. Proof that the child is disabled by mental or physical incapacity must be provided within 120 days of the child becoming age 19 and on an annual basis thereafter. Coverage will continue as long as incapacitated, but only in the event coverage does not cease for any other reason.
- A **Dependent** child who has been placed for adoption with a covered **Employee**, whether or not the adoption is final. The child must be enrolled within 30 days following the date of adoption or the date of placement for adoption and the child may not have reached 18 years of age on such date. Proof of adoption or placement for adoption must be provided to the employer at the time of the child's enrollment in this plan.
- This plan will also provide coverage as described by a **Qualified Medical Child Support Order** (QMCSO), issued by a qualifying court or an authorized administrative agency, that assigns a child the rights of a participant or beneficiary to receive benefits under this health plan. Children assigned benefits by a QMCSO must be enrolled within 30 days following the order. Children assigned benefits by a QMCSO must satisfy the pre-existing condition limitation provision and any other terms and conditions of the plan that apply to other **Dependents**. For further information regarding the plan procedures for governing QMCSO refer to Appendix A.

DUAL COVERAGE

If both you and your spouse are covered as **Employees** under this plan maintained by the **Corporation**, any **Dependent** children otherwise eligible may be considered **Dependents** under one or both plans. If both you and your spouse are covered as **Employees** under this plan, you may be considered **Dependents** under each other's plan.

If both you and your spouse are covered as **Employees** and coverage for one of you is terminated, the one who remains an **Employee** may immediately cover their spouse as a **Dependent** and may cover any **Dependents** who were covered under the spouse's coverage. enrollment of **Dependents** must be made within 30 days. If they are not added during that time, and they wish to enroll in this plan at a later date, it will be up to the **Plan Administrator** to determine eligibility and the effective date of coverage.

If only one of you is enrolled as an **Employee** and your spouse, who is also an **Employee**, enrolled as your **Dependent**, and coverage for you, as an **Employee**, is terminated, the spouse who was enrolled as a **Dependent** may immediately enroll as an **Employee** and may cover their spouse as a **Dependent** and may cover any **Dependents** who were covered under the spouse's coverage. This change in enrollment must be made within 30 days of the loss of coverage. If this change is not made during that time, and they wish to make this change at a later date, it will be up to the **Plan Administrator** to determine eligibility and the effective date of coverage.

WHO IS NOT ELIGIBLE?

- You, on the date employment terminates or the date you no longer meet eligibility as defined by this plan, except as described in HOW YOUR COVERAGE IS AFFECTED WHEN YOU ARE NOT AT WORK;
- You, the date you die;
- Your spouse on the date you are legally divorced or legally separated;
- Anyone for whom necessary contributions toward the cost of the coverage have stopped;
- Any individual who does not meet the definition of an **Employee** or **Dependent** as described in the section entitled WHO IS ELIGIBLE FOR BENEFITS?

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. Please refer to the section entitled COBRA CONTINUATION COVERAGE.

HOW DO YOU ENROLL FOR COVERAGE?

Human Resources can provide you with an **Enrollment Form**. If you complete, sign and return this form within the first 30 days of your **Coverage Effective Date**, you will be enrolled in this plan as described under WHEN WILL COVERAGE BEGIN.

If you are not added during that time, and you wish to enroll in this plan at a later date, it will be up to the **Plan Administrator** to determine eligibility and the effective date of coverage.

HOW TO APPLY FOR ENROLLMENT OF YOUR ELIGIBLE DEPENDENTS

At the time of your enrollment, you must either enroll or decline enrollment of your eligible **Dependents**. You may enroll your **Dependents** by listing them on your original **Enrollment Form** at the time you enroll for your own benefits.

If you do not enroll for coverage, your spouse and any **Dependents** are not eligible for coverage through this plan.

You may enroll **Dependents** later as explained in the section entitled LATE ENROLLMENT.

You need not enroll **Dependents** for coverage if they are covered by another group vision plan. If your spouse or **Dependents** lose coverage for any reason other than failing to make a required contribution, they may be enrolled in the Port Huron Hospital plan within 30 days of the loss of coverage without proof of good health. Proof of loss of coverage must be supplied. If you wish to add **Dependents** after this time period, you may do so as explained in the section entitled LATE ENROLLMENT.

WHEN WILL COVERAGE BEGIN?

If you and/or your eligible **Dependents** were covered by the plan maintained by the **Corporation** on December 31, 2001, and you and/or your eligible **Dependents** enrolled in this plan during the annual open enrollment prior to December 1, 2001, you and/or your eligible **Dependents** will be covered under this plan on January 1, 2002. (Only provided as a Flex Enrollment Option.)

If you and your eligible **Dependents** were in a waiting period status under the medical program maintained by the **Corporation** prior to January 1, 2002, time applied to the waiting period will be considered applied to the waiting period under this plan.

If you or an eligible **Dependent** are in the waiting period status when you or an eligible **Dependent** go on a military leave, the time you or they are on military leave will continue to be counted toward the waiting period.

All benefits will be calculated based on the coverage provided to the **Covered Individual** on the date the service is rendered.

HOW TO ADD NEW DEPENDENTS AFTER YOU ARE ENROLLED

After your original enrollment, you may add new **Dependents** to your coverage within thirty (30) days of those individuals becoming your eligible **Dependents**. To do so, you must provide the Human Resources with the following information in writing within that thirty (30) day period:

HOW TO ADD NEW DEPENDENTS AFTER YOU ARE ENROLLED (Continued)

1. The reason for the addition. (Example: newborn baby, adoption, marriage, etc.)
2. The name of each **Dependent**.
3. Their relationship to you.
4. Their dates of birth.
5. The date they became your **Dependents**. (Example: newborn baby - date of birth; adoption - date of adoption; marriage - date of marriage.)
6. Their social security number.

If you add your **Dependents** within the 30 day period specified above, their coverage will be effective as of the dates they became your **Dependents**. If they are not added during that period, you may add them as explained in the section entitled LATE ENROLLMENT.

FAMILY AND MEDICAL 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 Family/Medical leave.

This section provides information concerning qualifications and extension of this plan's benefits. If you do not qualify, are not granted, or exceed the time allowed under FMLA, all regular plan provisions will apply.

You are a qualified **employee** if:

- You have worked for the **Corporation** for at least 12 months, and
- You have worked for at least 1,250 hours during the year preceding the start of the leave.

A qualified **employee** is entitled to leave under the FMLA for:

- Birth of a child and to care for such child (up to 12 months after the birth of the child).
- Placement of a child for adoption or foster care (up to 12 months after the placement of the child).
- Care of your seriously ill spouse, child or parent.
- A serious health condition that makes you unable to perform your job functions.

If you are a qualified **employee**, you are entitled to up to 12 weeks of leave in a 12-month period under the FMLA. The 12-month period will be measured looking back 12 months from the date the leave is used.

During the time you are granted leave under the FMLA, your regular contribution for coverage will be required. Your contribution must be paid at the same time, as it would be if made by payroll deduction.

You will be allowed a 30-day grace period from the due date to make premium payment. If payment is not made during that time, your coverage will be suspended when the grace period ends.

FAMILY AND MEDICAL LEAVE (Continued)

If you do not return to work at the end of your leave, the **Corporation** will have the right to collect the cost of you and your covered **dependents** coverage during the leave. This cost is limited to the then effective **COBRA** rates (less the 2% allowable administrative cost in the **COBRA** rate). This provision does not apply if you do not return to work for:

- A serious health reason (either affecting you or an immediate family member) that would entitle you to leave under FMLA; or
- Other circumstances beyond your control.

If you fail to pay a contribution during your leave, coverage will be suspended. Coverage will resume, when you return to work, as though it had not been lost and no waiting period will be imposed.

If your coverage ends due to failure to pay a required premium or if you do not return to work, you and/or your covered **dependents** may continue coverage as provided under **COBRA**. The maximum **COBRA** coverage period begins on the last day of your FMLA leave, the qualifying event date.

If you elect **COBRA**, no proof of good health will be required. If you or your **dependents** were in a **pre-existing condition** limitation waiting period, that period will continue to be counted from the qualifying event. Any condition occurring during the time coverage was suspended will not be subject to the **pre-existing condition** limitation.

Unless a longer period is allowed under this plan's regular termination provisions:

- If you fail to pay a required contribution during your leave, your **COBRA** qualifying event date will be the last day of your qualified leave.
- If you fail to return to work after your leave, your **COBRA** qualifying event date will be the last day of your qualified leave or the date you notify the **Corporation** of your intention not to return to work, whichever is earlier.

WHAT OTHER CHANGES SHOULD YOU REPORT?

Whenever any of the information you reported on your **Enrollment Form** changes, you must immediately advise Human Resources. Since this vision benefits plan is administered on the basis of the information on that **Enrollment Form**, your records must be kept up to date. Those changes include:

- change of address,
- change of name due to marriage or divorce,
- change in your spouse's or **Dependent's** vision coverage,
- your divorce or legal separation, and
- change in the eligibility status of your **Dependents**.

CHANGES IN FAMILY STATUS

IRS regulations require that your benefit elections remain in force for the full plan year (January 1 – December 31). The only exception that permits you to change your election during the year occurs when you experience a qualified change in family status (as defined under the Internal Revenue Code) that directly affects your participation in the plan. Your election is irrevocable except as allowed in the IRS temporary proposed and final regulations.

Under current Federal tax rules, the following situations are examples of qualified family status changes:

1. Change in marital status, including marriage, divorce, legal separation, annulment or death of spouse.
2. Change in number of **Dependents**, including birth, death, adoption, and placement for adoption. This extends to **Dependents** that become newly eligible for plan coverage because of a plan amendment.
3. Change in employment status of the **Employee**, spouse or **Dependent**, including 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 lockout, change from salaried to hourly pay. (For rehires within 30 days of termination, previous election will be reinstated. For rehires after 30 days from termination, treat like new **Employee** and allow a new election)
4. **Dependent** meeting or ceasing to meet the plan's definition of **Dependent**, such as attainment of a specified age or ceasing to be a student.
5. Mid-year eligibility for or loss of Medicare or Medicaid.
6. A judgment, decree or order requiring **Dependent** coverage (e.g., QMCSO).

CHANGES IN FAMILY STATUS (Continued)

A consistency requirement applies to change in status events for mid-year election changes and consists of three parts:

1. The change in status event must cause an individual to gain or lose eligibility for benefits under one of the underlying plans or the cafeteria plan, or under another employer's plans or for one of the benefit options under a plan; and
2. The mid-year election change must be "on account of" the change in status; and
3. The mid-year election change must "correspond with" the change in status that caused a gain or loss of plan eligibility.

If you experience a family status change, please contact your Human Resources immediately so that they can provide you with the information you will need to make any changes allowed. You must make these changes within 30 days of the event.

WHEN WILL COVERAGE END?

Your coverage and that of your enrolled **Dependents** will end at the end of the month of your last day of employment. There may be extensions of coverage available. Please refer to the section of this booklet entitled HOW YOUR COVERAGE IS AFFECTED WHEN YOU ARE NOT AT WORK.

In addition, the coverage of your **Dependents** will end when, as explained in the ELIGIBILITY section of this booklet, they are no longer your **Dependents**.

NOTE: If your coverage terminates or if a **Dependent** ceases to be covered for any of the above reasons, you and/or your **Dependents** may be eligible to continue coverage under the plan. Please refer to the section entitled COBRA CONTINUATION COVERAGE.

LATE ENROLLMENT

If you do not enroll yourself or **Dependents** when originally eligible, you may enroll at a later date if there is a change in family status. Coverage will be effective on the first of the month following your enrollment.

OPEN ENROLLMENT

The annual open enrollment period will be held as announced by the **Corporation** for coverage which is to be effective on the following September 1. Each even numbered year you will be offered the opportunity to elect participation in the Vision Benefits Plan or elect no coverage. If you elect no coverage, you will be ineligible to participate for all of that year and the next year. Similarly, if you elect to participate, you must continue to participate for both that year and the next year. During the open enrollment period in an even numbered year, **Employees** may add **Dependents** under this plan who were previously eligible but not enrolled.

OPEN ENROLLMENT (Continued)

For **Employees** and **Dependents** who were previously eligible but not enrolled in either this plan or any **Corporation** plan and who are first enrolling for coverage during open enrollment, proof of good health will not be required.

Vision coverage is available to active full-time and active part-time **Employees** and their **Dependents**.

HOW YOUR COVERAGE IS AFFECTED WHEN YOU ARE NOT AT WORK

(Please refer to your Employee Handbook for further details.)

If you are on an approved work related medical leave of absence, then

Your coverage and that of your covered **Dependents** will continue to a minimum of the first 12 weeks of absence. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

If and when you and your eligible **Dependents** no longer qualify for coverage as provided above, you and your eligible **Dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE.

If you are granted an approved non-work related medical leave of absence as detailed in your Employee Handbook, then

Your coverage and that of your **Dependents** will continue through the first 12 weeks of any leave of absence except personal, education or military leave, provided the **Employee** continues to fulfill any established FLEX enrollment deductions. If the leave is greater than 12 weeks, or if it is for personal or educational purposes, these benefits will continue as long as the **Employee** is receiving a bi-weekly pay check from the Hospital equivalent to his/her base earnings through eligible benefit banks. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

When you and your eligible **Dependents** no longer qualify for coverage as provided above, you and your eligible **Dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE.

If you are on an approved personal unpaid leave of absence, then

Your coverage and that of your covered **Dependents** will end at the end of the pay period you go on an unpaid approved personal leave. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

When you and your eligible **Dependents** no longer qualify for coverage as provided above, you and your eligible **Dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE.

If your employment is terminated through a reduction in work force (layoff) anticipated being less than 90 calendar days, then

Your coverage will continue until the end of the month following 12 weeks from the date the layoff occurred. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

You and your **Dependents** may be eligible for continuation coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE

HOW YOUR COVERAGE IS AFFECTED WHEN YOU ARE NOT AT WORK (Continued)

If your employment is terminated through a reduction in work force (layoff) anticipated being greater than 90 calendar days, then

Your coverage will continue until 12 weeks from the date the layoff occurred. **Employees** with more than 12 weeks of seniority will receive an additional week of coverage for each additional year of seniority up to a total of 26 weeks for 26 or more years of seniority. Coverage will end at the end of the month. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

You and your **Dependents** may be eligible for continuation coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE

If your employment is terminated voluntarily or involuntarily, then

Your coverage and that of your covered **Dependents** will end at the end of the month that you terminate. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

You and/or your covered **Dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE.

If your employment is terminated due to retirement and you have not qualified as any eligible retiree, then

Your coverage and that of your covered **Dependents** will end at the end of the month you retire. REFER TO YOUR EMPLOYEE HANDBOOK FOR FURTHER DETAILS.

You and/or your covered **Dependents** may be eligible for continuation of coverage (available at your own expense). Please refer to COBRA CONTINUATION COVERAGE.

If your employment terminates due to death, then

If, at the time of your death, you are not eligible for retirement, coverage for your **Dependents** will terminate at the end of the month following the month in which your death occurs. After that time, your **Dependents** may be able to elect to continue benefits (available at their own expense). Please refer to COBRA CONTINUATION COVERAGE.

HOW YOUR COVERAGE IS AFFECTED WHEN YOU ARE NOT AT WORK (Continued)

If you are on an approved absence covered by the Family Medical Leave Act (FMLA), then

Your coverage and that of your **dependents** will continue for up to 12 weeks of leave provided total leave time in the 12 preceding months does not exceed 12 weeks. Example - If you are on leave on June 1, 2002, the prior 12 months would be June 2, 2001 to June 1, 2002. If you are still on leave on June 2, 2002, the prior 12 months would be June 3, 2001 to June 2, 2002. You must pay any premiums for you and your **dependents** you would have been required to pay even if you weren't on leave. Refer to Family and Medical Leave Act.

Your coverage may be extended beyond 12 weeks if your leave is for medical reasons as detailed under non-work related medical leave above.

COBRA CONTINUATION COVERAGE

COBRA COVERAGE

Under certain circumstances you and/or your covered **Dependents** have the right to continue coverage in the plan, at your/their expense, beyond the time coverage would normally end.

Your **Dependents** include children born or placed for adoption with the covered **Employee** during the period of continuation coverage.

WHEN IS PLAN CONTINUATION COVERAGE AVAILABLE?

Continuation coverage is available if your coverage or a covered **Dependent's** coverage would otherwise end because:

- Your employment ends for any reason other than your gross misconduct; or
- Your hours of work are reduced so that you are no longer an **Employee** or to less than the minimum required to meet eligibility requirements; or
- You are divorced or legally separated; or
- You die; or
- Your child is no longer eligible to be a covered **Dependent** (for example, because he or she turns 19.

HOW TO CONTINUE COVERAGE

If coverage would end because of divorce or legal separation, or because your child is no longer eligible to be a **Dependent**, you or your covered **Dependent** must notify Human Resources immediately. If Human Resources is not notified within 60 days after coverage would otherwise end, coverage cannot be continued.

When Human Resources receives this notice (or when your employment ends, your hours of work are reduced so you are no longer an **Employee** eligible for group benefits or you die), you and your covered **Dependents** will be notified about your/their right to continue coverage. If you or a covered **Dependent** wants to continue coverage, you, he or she must elect to do so within 60 days of the later of the date your coverage ends or on the date of the notice. (You and each of your covered **Dependents** can individually decide whether or not to continue coverage, but the election of coverage by you or your spouse will be considered to be an election by all **Covered Individuals**, unless another **Covered Individual** rejects coverage.)

COSTS

Continuation coverage is at your expense. The monthly cost of this continued coverage will be included in the notice sent to you. This cost may be adjusted from time to time. Payments are the same for all individuals who are in the same type of classification - adult single individuals have the same cost and family groups have the same cost.

For coverage to continue, the first payment must be received by the date stated in the notice sent to you. The first payment due date will be 45 days after the date of continuation coverage election. Your first premium payment must be made retroactive back to the date when your coverage terminated. Payments for every following month of continuation coverage must be paid monthly on or before the payment due date stated in the notice sent to you. There is a 30 day grace period for these monthly payments. If they are not paid within 30 days after their due date, continuation coverage will end as of the first day of that period of coverage and cannot be reinstated.

HOW LONG CAN CONTINUED COVERAGE BE ELECTED?

If coverage would otherwise end because your employment ends or your hours are reduced so you are no longer eligible for group benefits, continuation coverage for you and/or your covered **Dependents** may continue until the earliest of the following:

- 18 months from the date of loss of coverage.
- The date on which a premium payment was due but not paid.
- The date after the **COBRA** election, the person continuing coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects coverage of a **Covered Individual's** pre-existing condition.
- The date after the **COBRA** election the person becomes entitled for Medicare.
- The date the **Corporation** terminates all of its group health plans.

If coverage would otherwise end for a covered **Dependent** (spouse or child) because of divorce, legal separation, death or a child's loss of dependency status, continuation coverage may continue until the earliest of the following:

- 36 months from the date your covered **dependent's** coverage would have otherwise ended.
- The date on which a premium payment was due but not paid.
- The date after the **COBRA** election, the person continuing coverage becomes covered by another employer's group health plan and that plan does not contain any exclusion or limitation that affects coverage of a **Covered Individual's** pre-existing condition.
- The date after the **COBRA** election the person becomes entitled for Medicare.
- The date the **Corporation** terminates all of its group health plans.

SPECIAL RULE

Second Qualifying Event

If continuation coverage was elected by a covered **Dependent** because your employment ended or your hours were reduced so you and your covered **Dependent** are no longer eligible for group benefits and if, during the period of continued coverage, another event occurs which is itself a condition for availability of continued coverage, the maximum period of continued coverage for the covered **Dependent** is extended for 18 months, i.e., to a maximum of 36 months from the date your employment ended or your hours were reduced. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Spouse and Dependents of Medicare-Entitled Employees

If continuation coverage is elected by the spouse or **Dependent** child of a covered **Employee** who became entitled to Medicare while an **Employee**, the maximum period of continuation coverage for the spouse or child is the greater of 36 months from the date the covered **Employee** became entitled to Medicare or 18 months from the date the **Employee** loses coverage. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.)

Disabled Individuals

If a **Covered Individual** is disabled as determined by the Social Security Act at the time he/she first becomes eligible for **COBRA** continuation coverage or within 60 days of becoming eligible, the maximum period of continuation coverage is extended to 29 months. If you are disabled, you must submit a copy of the Social Security Award letter. (Coverage will still end for any of the other reasons listed above, such as failure to pay premiums when due, etc.). The **Covered Individual** must notify Human Resources within 60 days of the date he or she is determined to be disabled under the Social Security Act and within 30 days of the date he or she is finally determined not to be disabled. (Coverage will end on the first day of the month beginning after 30 days after the **Covered Individual** is determined not to be disabled.) The cost of continuation coverage may increase after the 18th month of continuation coverage.

BANKRUPTCY

If you have plan coverage as a retiree from Port Huron Hospital and if Port Huron Hospital substantially eliminates the coverage you or your covered **Dependents** would otherwise have within one year before or after the date Port Huron Hospital begins a bankruptcy proceeding, you and/or your covered **Dependents** have the right to continue coverage in the plan, at your/their expense. The procedure for continuing coverage and your cost is the same as stated above. Coverage will continue until the earliest of the following:

- The date on which a payment was due but not paid.
- The date the person continuing coverage becomes covered by another employer's group health plan that does not contain any exclusion or limitation that affects coverage of a **Covered Individual's** Pre-existing Condition.
- The date the **Corporation** terminates all of its group health plans.
- The date the person continuing coverage dies.
- Thirty-six (36) months from the date the covered retiree dies.
- The date coverage is permitted to end under ERISA or the Internal Revenue Code.

WHAT IF YOUR CLAIM FOR BENEFITS IS DENIED?

If your claim for benefits is denied - in whole or in part - the **Plan Supervisor**, NGS American, Inc., will give you a written notice that explains the reason(s) for denial, with a reference to the Benefit Plan provision upon which the denial is based. If your claim is denied because you did not submit enough information or documentation, the written notice will tell you what is missing so that you can resubmit the claim. The written notice will also give you an explanation of the claim review procedure.

Once a claim is properly submitted, the **Plan Supervisor**, NGS American, Inc. will make a decision on whether the claim will be paid or denied within a reasonable period of time. This decision will be made in writing within ninety (90) days of when the properly submitted claim was originally filed. In special cases, if the **Plan Supervisor**, NGS American, Inc. notifies you that more time is needed, an additional ninety (90) days is permitted to make the necessary decision.

If you feel that your claim was processed incorrectly you can file an appeal to the **Plan Supervisor**, NGS American, Inc. Your appeal must be in writing and must include the reason(s) you believe your claim was improperly processed. You must file the appeal within sixty (60) days from the date on which the written notice denying your claim - in whole or in part - was sent to your address of record. Your appeal should be addressed to the **Plan Supervisor**, NGS American, Inc., at P.O. 7676, St. Clair Shores, MI 48080.

If your appeal is denied by the **Plan Supervisor**, NGS American, Inc., you have right to appeal to the **Plan Administrator, Port Huron Hospital**. During the course of the claim review, you have the right to see all documentation that affects your claim. You can submit your argument to the **Plan Administrator, Port Huron Hospital** in writing, or you can request a hearing before the **Plan Administrator**. Your request for a hearing must be in writing and should be addressed to **Port Huron Hospital**, Human Resources, 1221 Pine Grove Avenue, P.O. Box 5011, Port Huron, MI 48061-5011, (810) 989-3108. At the hearing you can bring a representative on your behalf, but in no event will the **Corporation** incur any additional costs in connection with your presence or that of your authorized representative.

The **Plan Administrator** reserves the right to grant a hearing at its own discretion based on the individual merits of each case. The **Plan Administrator** will consider all the available evidence in connection with the denied claim and issue its decision to you in writing. The decision will be written in a manner meant to be clear and understandable with the exact reason(s) stated and reference to benefit plan provision(s) cited. The **Plan Administrator** will ordinarily consider your appeal within sixty (60) days of the receipt of your appeal; however, there are some exceptions. If further information is required by the **Plan Administrator** before it can make a decision, it may take an additional thirty (30) days to issue a decision. The **Plan Administrator** must notify you to explain any delays.

The **Plan Administrator** has the full discretionary authority to make the final decision on your claim if it is appealed.

HOW WILL THIS PLAN WORK WITH OTHER COVERAGES?

There may be times when this plan is not the only source of benefits for you and your covered **Dependents**. You may have other coverage provided by:

- Another group health plan
- Medicare
- Motor vehicle plan

When this plan is **Primary**, it will pay according to the plan benefits described in this booklet. When this plan is **secondary**, the **Plan Supervisor** will calculate benefits and then subtract the amount paid by the **primary** plan. However, even when the plan is **secondary**, it will never pay more than it would if were the **primary** plan.

This plan uses established guidelines when there are other sources of benefits in order to determine when it pays first, as the primary source of benefits, or when it pays after other coverage, as the secondary source of benefits.

The plan will also coordinate benefits on a **Secondary** basis if the **Covered Individuals** have National Healthcare, such as Canadian residents.

Port Huron Hospital reserves the right to limit coverage on a **Secondary** basis by any penalties imposed by the **Primary** carrier for the patient's failure to pre-certify an Inpatient stay.

EXAMPLE:	Charges	\$200
	Primary Plan Payment:	<u>-\$150</u>
	Balance	\$ 50
	This Plan would normally pay	\$190
	Payment by this Plan as Secondary	\$ 40

The plan does provide for Coordination of Benefits between married **Employees**, both husband and wife, who are employed by Port Huron Hospital.

If an **Employee** participates in two vision benefits plans, one under Port Huron Hospital and one under another employer, benefits will be paid as **Primary** coverage under the plan where the **Employee** has been covered the longest.

Generally, this plan will be **Primary** if the claimant is an active **Employee**, or a **Dependent** child if the active **Employee's** birthday is earlier in the year than the **Employee's** spouse. Generally, this plan will be **Secondary** to a plan covering the spouse as an active **Employee** or as a retiree. The following are specifics:

HOW WILL THIS PLAN WORK WITH OTHER COVERAGES? (Continued)

IF THE CLAIMANT IS AN ACTIVE EMPLOYEE

THE PLAN WILL BE **PRIMARY** TO:

- a plan covering you as a **Dependent**,
- a plan covering you as a **COBRA** participant,
- a plan covering you as a retiree, or
- a plan covering you as a **Dependent** of a retiree in another group plan.

IF THE CLAIMANT IS THE SPOUSE OF AN ACTIVE EMPLOYEE

THE PLAN WILL BE **PRIMARY** TO:

- a plan covering the spouse as a **COBRA** participant, or

THE PLAN WILL BE **SECONDARY** TO:

- a plan covering the spouse as an active **Employee**.
- a plan covering the spouse as a retiree.

IF THE CLAIMANT IS A CHILD OF AN ACTIVE EMPLOYEE

THE PLAN WILL BE **PRIMARY** TO:

- a plan covering the child as a **Dependent** of the **Employee's** spouse, provided the spouse is also an active **Employee**, if the **Employee's** birthday (day and month) is earlier in the year than the **Employee's** spouse,
- a plan covering the child as a **COBRA** participant or a **Dependent** of a **COBRA** participant, or
- a plan covering the child as a **Dependent** of a retiree, if the employee's birthday (day and month) is earlier in the year than the employee's spouse.

If both parents covered as active **Employees** have the same birth date, the plan in effect the longest will be **Primary** for the **Dependent** child.

THE PLAN WILL BE **SECONDARY** TO:

- a plan covering the child as a **Dependent** of the **Employee's** spouse, provided the spouse is also an active **Employee**, if the **Employee's** birthday (day and month) is later in the year than the **Employee's** spouse.

When a **Dependent** child is covered by more than one plan and there is a divorce, special rules apply.

HOW WILL THIS PLAN WORK WITH OTHER COVERAGES? (Continued)

IF THE CLAIMANT IS A CHILD OF AN ACTIVE EMPLOYEE AND A DIVORCE DECREE ESTABLISHES WHAT PARENT MUST PROVIDE PRIMARY COVERAGE AND/OR THE ORDER OF PAYMENT, THIS PLAN WILL FOLLOW THE DIVORCE DECREE

IF RULES ARE NOT ESTABLISHED BY THE DIVORCE DECREE -

THE PRIMARY PLAN WILL BE:

- the plan that covers the parent who has custody of the child.

THE SECONDARY PLAN WILL BE:

- the plan that covers the stepparent who has custody of the child.

Coverage may also be provided after **Primary** and **Secondary** coverage by:

- the plan which covers the parent who does not have custody of the child; or
- the plan that covers the stepparent who does not have custody of the child.

If there is a divorce decree that orders joint custody and does not determine **Primary** status for benefit coverage, the plan's regular provisions establishing the **Primary** status for children of active **Employees** will apply.

IF THE CLAIMANT IS A COBRA PARTICIPANT IN THIS PLAN

THIS PLAN WILL BE SECONDARY TO:

- a plan covering the claimant as an active **Employee**,
- a plan covering the claimant as a **Dependent** of an active **Employee**,
- a plan covering the participant as a retiree, or
- a plan covering the participant as a **Dependent** of a retiree.

If a claimant is covered by another plan as a **COBRA** participant then the **Primary** plan will be the plan in effect the longest.

HOW WILL THIS PLAN WORK WITH OTHER COVERAGES? (Continued)

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 State 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 State 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**).

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.

NOTE: If services are due to an accidental **Injury** and are covered under the medical plan, then they are not covered under the vision plan.

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, and 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 a covered person in a time of need, however, the Plan may pay covered expenses that may be or 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, a covered person is subject to, and agrees to, the following terms and conditions with respect to the amount of covered expenses paid by the Plan:

1. Assignment of Rights (Subrogation). The covered person automatically assigns 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 the covered person 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.

REIMBURSEMENT OF PLAN PAYMENTS (Continued)

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, ___ US ___ (1/8/2002). The provisions of the Plan concerning subrogation, equitable liens and other equitable remedies are also intended to supercede 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. The covered person has 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.

Failure by a covered person 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.

VISION BENEFITS

The plan provides benefits for services related to vision care and correction. Services for vision care may be provided by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Optometry (DO) and optical laboratory or an optician.

Vision care services are covered at 100% of the scheduled amount. Covered services are limited to one examination and set of lenses (single, bifocal, trifocal or lenticular) and one pair of frames OR one examination and one set of contact lenses (**Medically Necessary** or cosmetic) per two-year election period.

The plan will cover visual testing by an optometrist or ophthalmologist, including history, testing visual acuity (sharpness of vision), internal and external examination of the eyes, tonometry (testing for glaucoma, including medications for dilating pupils and desensitizing eyes), binocular measure and ophthalmoscope, when necessary.

The following **Physician's** service or treatment is payable up to the amount shown, and each service is limited to one per two year election period.

SERVICE OR TREATMENT	BENEFIT
Complete exam with refraction	\$ 35.00
Single lens (per pair)	\$ 45.00
Bifocal lens (per pair)	\$ 75.00
Trifocal lens (per pair)	\$ 90.00
Lenticular lens (per pair)	\$120.00
Medically Necessary Contacts (per pair)	\$190.00
Cosmetic Contacts (per pair)	\$ 95.00
Frames (each)	\$ 50.00

The plan pays the scheduled benefit for the covered charges per every two year election period.

Eye examination

Complete case history

Examination of funds, media, crystalline, lens, optic, disc and pupil reflex for pathological anomalies or **Injury**

Corneal curvature measurements

VISION BENEFITS (Continued)

Retinoscopy

Muscle balance

Refraction

Stereopsis determination, distant and near

Color discrimination

Amplitude of accommodation

Analysis of findings

Determination of prescription

Measuring and recording of visual acuity, distance and near, corrected and uncorrected, with new prescription, if required.

Glaucoma test

Visual field analysis

Slit lamp examination

Lenses and frames which may include

- Professional advice on frame selection
- Facial measurements and preparation of specification for optical laboratory
- Verification and fitting of prescription glasses

Services required to fit, administer or prepare subnormal vision aids including contact lenses, telescopic lenses and other similar devices when medically necessary to improve vision to 20/70 in the better eye, when vision cannot be corrected by conventional lenses.

WHAT IS NOT COVERED BY THIS PLAN?

This vision plan allows for payment of only **Reasonable And Customary** charges for necessary services which are incurred after the **Coverage Effective Date** of the **Covered Individual** and before his or her **Coverage Termination Date**. There are many situations where benefits may be limited or not provided by this plan.

GENERAL EXCLUSIONS

The following charges are not covered by any portion of this plan:

Expenses which apply to the deductible and exceed the fee schedule

Services or supplies which are not **Medically Necessary**

Services and supplies not prescribed or provided by a Doctor of Medicine (MD), Doctor of Osteopathy (DO), Doctor of Optometry (OD), Optical Laboratory or an Optician

Charges in excess of those considered **Reasonable And Customary**

Charges for any vision services, to the extent that they are paid by an employer sponsored group medical plan

Vision testing examination more frequently than once every two year election period.

Vision testing examinations, lenses or frames furnished for any condition, disease, ailment or **Injury** arising out of and in the course of employment

Vision testing examinations and lenses and frames ordered before the **Covered Individual** became eligible for coverage or after the **Coverage Termination Date**

Charges for vision testing examinations, lenses or frames for which no charge is made that the **Covered Individual** is legally obligated to pay or for which no charge would be made in the absence of this vision benefits plan

Charges for vision testing examinations, lenses or frames which are not necessary or do not conform with accepted standards of optometric practice or which are not ordered or prescribed by a **Physician** or optometrist

Charges for vision testing examinations, lenses or frames which do not meet accepted standards of optometric practice, including charges for any such services or supplies which are experimental in nature

Charges for vision testing examinations, lenses or frames received as a result of eye disease, defect or **Injury** due to an act of war, declared or undeclared

Charges for vision testing examinations, lenses or frames from any governmental agency which are obtained by the **Covered Individual** without cost by compliance with law or regulations enacted by any Federal, state, municipal or other governmental body

WHAT IS NOT COVERED? (Continued)

Sunglasses to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided in the plan

Photosensitive or anti-reflective lenses to the extent the charge for such lenses exceeds the benefit amount for regular lenses as provided by the plan

Medical or surgical treatment. Benefits may be available as explained in the section entitled VISION CORRECTION in your medical benefits plan

Charges for the completion of any claim form

Drugs or other medication not administered for the purpose of a vision testing examination

Charges for services or supplies not rendered, including charges for canceled appointments

Services rendered for treatment of any **Illness** or **Injury** for which benefits are available under Worker's Compensation or Employer Liability Law

Covered charges when there has been an incomplete claims submission

Research studies

Charges for treatments, consultations or visits which consist of a telephone conversation

Services rendered in a hospital operated by a state or the U.S. Government or an agency of the government or charges for which coverage is required by or available through any federal, state, municipal or other governmental body or agency

Charges made by a Veteran's Administration Hospital unless they are not related to a service connected **Injury** or **Illness**

Services or supplies not listed on the Schedule of Benefits

Special supplies such as non-prescription sunglasses

Anti-reflective coatings or tinting

Radial keratotomy

Duplicate or spare lenses or frames

Charges for any service which should be provided by a **Primary** plan

Services, care, treatment and referrals rendered by the **Covered Individual's** family, including -but not limited to - spouse, mother, father, grandmother, grandfather, in-laws, brother, sister, half-brother or half-sister, step-children, son, daughter, aunt, uncle, cousin, niece, nephew, grandson or granddaughter or anyone who resides in the household

Claims filed later than the end of the year following the year in which the charge was incurred.

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.

WHAT IS MEANT BY...?

Whenever the following words and phrases appear capitalized, they shall have the meaning explained below unless the context otherwise requires.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985 requires group health plans of covered **Employees** to provide **Employees** and family members the opportunity to continue health care coverage at their own expense, when coverage would be lost under certain circumstances.

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 their **Dependent's** benefits begin. (Refer to the section titled WHEN WILL COVERAGE BEGIN? for more information.)

Coverage Termination Date: The date on which the **Employee's** and/or their **Dependent's** benefits ends. (Refer to the section titled HOW YOUR COVERAGE IS AFFECTED WHEN...? for more information.)

Covered Individual: An eligible **Employee** or **Dependent** who is enrolled in the Port Huron Hospital Vision Benefits Plan as Amended and Restated January 1, 2002. (This includes only those people who qualify for enrollment as indicated in the ELIGIBILITY section of this plan.)

Covered Spouse: The **Employee's** legally married husband/wife who is enrolled in the Port Huron Hospital Vision Benefits Plan as Amended and Restated January 1, 2002. (This includes only those people who qualify for enrollment as indicated in the ELIGIBILITY section of this plan.)

Dependent(s): People who have the following relationship to an **Employee**:

- An **Employee's** lawful spouse;
- An **Employee's** unmarried **Dependent** children

(This includes only those people who qualify for enrollment in the ELIGIBILITY section of this 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 hours or more per week.

Enrollment Form: The form provided by the **Corporation** for your completion and signature to enroll you and your **Dependents** in the benefits plan.

WHAT IS MEANT BY...? (Continued)

Experimental/Investigational Services: This includes - medical, surgical, psychiatric, substance abuse or other health care technologies, supplies, treatments, diagnostic procedures, drug therapies or devices that are determined by the plan (at the time it makes a determination regarding coverage in a particular case) to be: (1) not approved by the U.S. Food and Drug Administration (FDA) to be lawfully marketed for the proposed use and not identified in the American Hospital Formulary Service as appropriate for the proposed use; or (2) subject to review and approval by any Institutional Review Board for the proposed use; or (3) the subject of an ongoing clinical trial that meets the definition of a Phase 1, 2 or 3 Clinical Trial set forth in the FDA regulations, regardless of whether the trial is actually subject to FDA oversight; or (4) not demonstrated through prevailing peer-reviewed medical literature to be safe and effective for treating or diagnosing the condition, **illness** or **diagnosis** for which its use is proposed.

NOTE: The **Plan Administrator** will have final discretion with respect to **experimental/investigational** services.

Illness: The condition of being sick or unhealthy as classified in the International Classification of Diseases (ICD-9).

Injury: A sudden, unexpected, and unforeseen bodily harm which occurs solely through external bodily contact.

Medically Necessary: Any service, supply or treatment deemed to be necessary for the treatment of an **illness** or **Injury**, prescribed by the **Covered Individual's Physician** or dentist, and professionally accepted as the usual, customary, and effective means of treating the condition. (However, diagnostic x-rays and laboratory tests which are performed due to definite symptoms of **illness** or **Injury** or reveal the need for treatment will be considered **Medically Necessary**.)

Physician(s): A qualified Doctor of Medicine (MD), Doctor of Osteopathy (DO) or Doctor of Optometry (OD), who, within the scope of their licenses, are permitted to perform services for which coverage is provided in this 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 the plan coverage, exclusions, and limitations which is the governing document for this plan.

Plan Effective Date: The original **Plan Effective Date** is September 1, 1994. The plan was amended and restated January 1, 2002.

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

Primary: First. (For example, in an instance where an individual has two (2) insurance coverages, the plan which covers the individual as an **Employee** will pay as **Primary** or first for charges incurred by that individual.)

WHAT IS MEANT BY...? (Continued)

Qualified Medical Child Support Order (QMCSO): an order of a court or authorized administrative agency requiring medical child support which meets the federal law requirements to be a **Qualified Medical Child Support Order**

Reasonable And Customary: A fee most frequently allowed for a similar service or vision procedure, which is charged by most similarly qualified **Physicians** or other health care providers in the particular geographic area where the service is rendered (it takes into consideration any unusual circumstances and medical complications which may require additional time, skill and experience).

Secondary: After first. (When used in the context of two different benefit coverages, the plan considered to be **Secondary**, through its coordination of benefits guidelines, calculates its available benefit payment after the plan which is considered to have **Primary** responsibility.)

Summary Plan Description: This summary of your benefits.

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

Totally Disabled: A condition under which an **Employee** is prevented because of **Injury** or disease from engaging in their customary occupation and is performing no work of any kind for pay or profit. (For the purpose of the Medical Plan, an enrolled **Dependent** 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 supervisor** is required to make a determination with respect to the total disability of an individual, the **Plan supervisor** shall have the right to require the individual to submit to an examination by a **Physician(s)**, or medical clinic selected by the **Plan supervisor**.)

APPENDIX A

PROCEDURES RELATING TO A QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

Upon receipt of a Medical Child Support Order or a National Medical Support Notice issued under applicable state or federal law, the **Plan Administrator** 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 the individual is no longer employed, falls 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 the **Employee's** income of the amount required to obtain coverage for the children specified,
6. If appropriate, withhold from the **Employee's** income any contributions required,
7. Notify the **Employee** 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, within 60 calendar days after being notified of the **Plan Administrator's** decision, that the Plan Sponsor again review the status of the Notice or Order. 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.

APPENDIX B

HOW DO YOU FILE A VISION CLAIM?

Your employer provides a Vision Benefits Plan which, as a convenience for you, intends to pay covered plan benefits, so that you should not have to use your own money for expenses this plan would otherwise pay. This is done through this plan's intent as expressed in the assumption of assignment. This means that this plan will always assume that it should pay the available benefit FOR you, directly to the provider of vision benefits upon receipt of the complete claim information UNLESS you have submitted proof of your payment.

This plan does not require vision claim forms. Your **Physicians**, optometrists, opticians and optical laboratories have their own methods of billing which, in most cases, provide sufficient information for claim consideration. The information that is needed can be determined by common sense:

1. The name of the patient.
2. The date of the service.
3. The specific services which were provided and by whom.
4. The charges for each specific service.
5. The medical condition for which treatment was provided.
6. Your name and the name of your employer.

If You Pay A Vision Bill And Are Submitting A Claim, then

The above provider information will be needed.

If you have already paid the bill, mail it along with your receipt or a copy of your canceled check to NGS American, Inc. All claims must be submitted to the **Plan Supervisor** no later than the end of the year following the year in which the charge was incurred. Any claims received later than this filing date will NOT be considered for payment.

If the bill is for your **Dependent** who has other vision coverage, mail a copy of the other coverage's proof of payment or denial.

If the bill 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**.

IF YOU HAVE PAID THE BILL and do not forward a receipt or a copy of a canceled check, this plan will assume that you did not pay the bill and will pay, on your behalf, the vision benefit directly to the provider. Therefore, **if YOU wish to be paid by this plan for expenses which you have already paid, you MUST forward a paid receipt or a copy of a canceled check.**

HOW DO YOU FILE A VISION CLAIM (Continued)

Things you need to know...

Your **Plan Supervisor** is NGS American, Inc., P.O. Box 7600, St. Clair Shores, MI 48080, (800) 251-1555.

Original bills and/or receipts with the complete claims information listed above should be sent to your **Plan Supervisor**, NGS American, Inc. Bills and/or receipts may be submitted either directly by the provider, or by you.

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

When NGS American, Inc. receives a bill, statement, or receipt, they will:

1. Determine if the service is covered by this plan.
2. Determine if additional information is needed from either you or the provider before the claim can be processed.
3. Determine if the charge is within the scheduled amount.

When additional information is needed from the provider, NGS American, Inc. will:

1. Contact the provider directly for the information.
2. Notify you that additional information has been requested.

When additional information is needed from you, NGS American, Inc. will:

1. Contact you directly for the information.
2. Notify the provider (if the bill has not been paid), that claim determination is pending the receipt of information from you.

When you receive a request for information, it is important for you to reply promptly. Your claim cannot be processed until the information that is asked for is supplied.

There may be times when you receive a bill directly from a provider. Any bill you receive should be forwarded to NGS American, Inc. When you forward a bill, you should supply any additional information you think will help NGS American, Inc. make a claim determination so that delay in processing may be avoided.

There are times when NGS American, Inc., may need additional information in order to process claims. You should be aware of some circumstances when you may be contacted for additional information.

HOW DO YOU FILE A VISION CLAIM (Continued)

IF the **Diagnosis** indicates that the patient may have been involved in an accident, you will be asked to advise how, when, and where the accident occurred. You may also be asked to indicate that if payment is provided from any other source, this plan will be reimbursed for any payment it makes.

IF the information presented with the claim does not correspond to information maintained by NGS American, Inc. (on your **Enrollment Form**), you will be asked to provide additional information so that those differences may be clarified.

IF the patient has other coverage, NGS American, Inc. may need to contact the other plan to determine who is **Primary** or **Secondary**. Please refer to HOW WILL THIS PLAN WORK WITH OTHER COVERAGE.

IF your plan is **Secondary**, NGS American, Inc. must be advised what the other plan has paid.

In certain cases, it may be necessary to have an independent **Physician** review medical information to resolve a claim.

Once NGS American, Inc. has all the necessary information, they will be able to determine if the services are covered by this plan and the extent of the benefit available to you from this plan.

When charges are covered by this plan, the **Plan Supervisor**, NGS American, Inc., will:

1. Compute this plan's payment
2. Issue this plan's payment directly to the provider
3. Send you a copy of a work sheet, Explanation of Benefits (EOB), showing how the plan's payment was calculated. This will also show the charge, amount paid, balance due, the name of the provider who received payment, and the date of the payment. You will always receive notification of this plan's payments.

**SUMMARY OF PLAN CHANGE TO THE
PORT HURON HOSPITAL
VISION BENEFITS PLAN
EFFECTIVE JANUARY 1, 2002**

EFFECTIVE JANUARY 1, 2003

The sections titled YOUR RIGHTS UNDER ERISA, DESIGNATION OF FIDUCIARY RESPONSIBILITY, ADMINISTRATION OF THE PLAN, and STATE OF MICHIGAN DISCLOSURE REQUIREMENT shall be deleted and replaced with the following:

YOUR 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 provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor.
- Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies.
- Receive a summary of the plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
- Continue health care coverage for you or your dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
- Reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to pre-existing condition exclusion. See the section titled PRE-EXISTING CONDITION LIMITATION for more information.

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. No one, including your employer, your union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Claims Administrator review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to \$110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a State or Federal court or bring a civil action under section 502A of ERISA. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in Federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquires, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue NW, Washington, DC 20210.

DESIGNATION OF FIDUCIARY RESPONSIBILITY

Port Huron Hospital is the Plan Administrator and named fiduciary, with respect to the plan 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 that is not specifically granted to another fiduciary.

Port Huron Hospital may delegate certain of its 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 which will be kept with the records of the plan.

NGS American, Inc. has, by written instrument been designated as the Fiduciary for Final Claims Determination for vision post-service claims submitted to the plan. By making this designation, it is the Plan Sponsor's intention that NGS American, Inc. make final claim determinations and have final discretion in construing the terms of the plan with respect to final

claim determinations. NGS American, Inc. shall not be responsible for any fiduciary responsibilities other than those outlined in this paragraph.

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.

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 herein, which shall be proper to enable him to carry out his duties under the plan, including by way of illustration and not limitation (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 not inconsistent 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 post-service vision claim decisions to NGS American, Inc. 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.

STATE OF MICHIGAN DISCLOSURE REQUIREMENT

Port Huron Hospital Vision Benefits Plan is a self-funded plan. Covered individuals in this plan are not insured. In the event this plan does not ultimately pay vision expenses that are eligible for payment under this plan for any reason, the individual covered by this plan may be liable for those expenses.

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

Complete and proper claims for benefits made by covered individuals will be promptly processed. In the event of a delay in processing, the covered individual shall have no greater right or interest or other remedy against the Claims Administrator, NGS American, Inc., than as otherwise afforded by law.

The section titled WHAT IF YOUR CLAIM FOR BENEFITS IS DENIED? on page 23 is deleted.

The following shall be added to the section titled WHAT IS MEANT BY...? on pages 35-37.

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.

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 a Pre-Service Urgent Care Claim, the plan will consider a health care professional with knowledge of a claimant's vision condition as an authorized representative.

If a covered employee or covered dependent wish 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.

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 Administrator and the address where to file appeals is as follows:

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

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

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

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

The definition MEDICALLY NECESSARY in the section titled WHAT IS MEANT BY...? on pages 35-37 is deleted and replaced with:

Medically necessary: any service, supply or treatment deemed to be necessary for the treatment of an illness or injury and professionally accepted as the usual, customary and effective means of treating the 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.

The following is deleted from the definition EXPERIMENTAL/INVESTIGATIONAL SERVICES in the section titled WHAT IS MEANT BY...? on pages 35-37.

NOTE: The **Plan Administrator** will have final discretion with respect to **experimental/investigational** services.

And replaced with:

NOTE: The **Claims Administrator** will have final discretion with respect to **experimental/investigational** services.

The following is added to the plan.

NOTICE OF AN ADVERSE BENEFIT DETERMINATION

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.

**SUMMARY OF PLAN CHANGE TO THE
PORT HURON HOSPITAL
VISION BENEFITS PLAN
EFFECTIVE JANUARY 1, 2002**

EFFECTIVE JANUARY 1, 2006

The section (PLAN NUMBER) under the section titled GENERAL PLAN PROVISIONS? on page 4 is deleted and replaced with:

The plan number is 510