ASCENSION HEALTH RETIREMENT
HEALTH REIMBURSEMENT ARRANGEMENT
(Effective January 1, 2013)
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ARTICLE 1. INTRODUCTION

1.1 Purpose of Plan. The purpose of this Plan is to enable Ascension Health and the entities associated with Ascension Health to provide their respective retired and disabled Employees with reimbursements for medical care expenses as defined in Code Section 213(d), and it is designed to comply with the requirements for exclusion from Employee income with respect to benefits and Employer contributions under Code Sections 105 and 106.

1.2 Health Reimbursement Arrangement Status. This Plan is intended to qualify as a “health reimbursement arrangement” or “HRA” as described in IRS Notice 2002-45 and is to be interpreted in a manner consistent with the requirements set forth in IRS Notice 2002-45 and IRS Revenue Ruling 2002-41, or any applicable subsequent IRS guidance.
ARTICLE 2. DEFINITIONS

As used in this Plan, the following words and phrases shall have the meanings set forth below, unless the context clearly indicates otherwise:

2.1 Associated Entity means the Sponsor and any entity which is:

(a) a member of the controlled group of corporations which includes the Sponsor, as determined in accordance with Code Section 414(b),

(b) a trade or business under common control with the Sponsor, as determined in accordance with Code Section 414(c),

(c) a member of an affiliated service group which includes the Sponsor, as determined in accordance with Code Section 414(m),

(d) any entity related to the Sponsor, as determined in accordance with Code Section 414(o), or

(e) any other entity associated with the Sponsor whose adoption of the Plan is approved by the Sponsor in writing.

2.2 Benefits Account means the notional individual account maintained on behalf of each Eligible Individual to reflect the total number of Credits allocated to such Eligible Individual. The Benefits Account shall be maintained for record-keeping purposes only and shall not require that any assets be set aside for the benefit of any Eligible Individual or other person. As of any date, the balance of the Benefits Account shall equal the Eligible Individual’s Credits plus any annual increases made under Section 4.3 minus any reimbursements made on or prior to that date.

2.3 Break in Service

(a) An Employee shall incur a Break in Service for any Plan Year (commencing with the Plan Year which includes the first anniversary of the date the Employee first performed one (1) Hour of Service) in which the Employee completes zero (0) Hours of Service.
Notwithstanding the foregoing, and solely for the purpose of determining whether a Break in Service has occurred, an Employee shall be credited for each Hour of Service the Employee otherwise normally would have been credited or, if such normal hours are not determinable, ten (10) hours per normal work day, if the Employee is absent from the service of his Employer due to a Parental Absence, Family and Medical Leave. Such Hours of Service shall be credited to the computation period immediately following the computation period during which such absence begins; provided, however, that such Hours of Service shall instead be credited to the computation period in which such absence begins if the Hours of Service so credited prevent the Employee from incurring a Break in Service during such earlier computation period.

2.4 Code means the Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.

2.5 Credits means the dollar value which is credited to a Eligible Individual’s Benefits Account through Employer Contributions which Participants may elect to receive in cash as reimbursement for Qualifying Medical Expenses.

2.6 Disabled Participant. A Participant will be considered disabled if such Participant is eligible for and receiving Social Security disability benefits and is no longer an Employee of any Associated Entity because of such disability.

2.7 Effective Date means January 1, 2013, or such later date as the Plan may be adopted by an Employer.

2.8 Eligible Individual means any individual who is an Employee and meets the requirements to receive Credits under Article 3.

2.9 Employee means any individual employed by an Associated Entity identified on Attachment 1, any individual employed by an Associated Entity who has separately adopted this Plan for all or a portion of its employees, or any individual who is a participant in the Ascension Health Executive Benefit Plan, but does not include an independent contractor. Such term shall include a “leased employee” within the meaning of Code Section 414(n)(2) who performs services for an Employer or an Associated Entity.

2.10 Employer means the Associated Entity that has adopted this Plan.
2.11 **Employer Contributions** means Employer contributions which are converted to Credits and awarded to Eligible Individuals as provided in Section 4.1 and 4.3.

2.12 **Entry Date** means January 1.

2.13 **Highly Compensated Individual** means any person who is a highly compensated individual, as defined in Section 105(h)(5) of the Code.

2.14 **Hours of Service** means the hours of employment with an Employer for which an Employee shall be credited, as follows:

   (a) **Hours Paid and Worked.** One (1) Hour of Service for each hour, not including on-call hours, for which the Employee is directly or indirectly paid or entitled to payment for the performance of duties during the applicable computation period for which his Hours of Service are being determined under the Plan. (These hours shall be credited to the Employee for the computation period or periods in which the duties were performed.)

   (b) **Hours Directly Paid but Not Worked.** One (1) Hour of Service for each hour for which the Employee is directly paid or entitled to payment for reasons other than for the performance of duties during the applicable computation periods, such as a leave of absence, vacation, holidays, short and long term disability (if reported as compensation on a Form W-2), and similar paid periods of nonworking time.

   Notwithstanding the foregoing, an Employee shall not be credited for hours associated with low-census payments, severance payments, cashouts of amounts paid from any bona fide vacation leave, paid time off, sick leave, payments from a compensatory time off program provided as a component of the Employer’s standard compensation practices.

   (c) **Hours Indirectly Paid but Not Worked.** One (1) Hour of Service for each hour for which the Employee is indirectly paid other than for the performance of duties during the applicable computation periods, such as periods of absence due to illness or injury and similar periods of nonworking time. However, no credit shall be given for Hours of Service attributable to Workers’ Compensation or for Hours of Service attributable to short-term and long-term disability as paid by an administrative third-party vendor.

   (d) **Hours Credited to Employees Absent from Employment by Reason of Qualified Military Service.** The number of normally scheduled hours for each week the Employee is absent from employment due to qualified military service, provided the
Employee returns to work as an Employee within the time prescribed by the Uniformed Services Employment and Re-employment Rights Act of 1994 or any subsequent law relating to veterans’ reemployment rights.

(e) **Back Pay.** One (1) Hour of Service for each hour for which the Employee is credited with compensation, irrespective of mitigation of damages, due to back pay which is either awarded or agreed to by the Employer.

(f) **Unpaid Leave of Absence.** Notwithstanding the foregoing, no Hours of Service shall be credited to an Employee for an unpaid leave of absence except for qualified military service.

(g) **Unemployment Compensation.** Notwithstanding the foregoing, no Hours of Service shall be credited to an Employee by reason of a payment made or due under a plan maintained solely for the purpose of complying with applicable unemployment compensation or disability insurance laws.

(h) **No Time Records.** With respect to an Employee for whom time records are not available or convenient for determining Hours of Service required to be credited as provided above, the Employee shall be credited with one hundred ninety (190) hours for each month or portion thereof for which he would be required to be credited with at least one (1) Hour of Service under subsections (a) through (g) above. Hours of Service shall be determined in accordance with reasonable standards and policies adopted by Ascension Health in conformance with Code Section 410(a)(3)(C) and related regulations, which are incorporated herein by reference.

(i) If an Associated Entity becomes an Employer, for purposes of determining the Hours of Service of an Employee of such Associated Entity, the Plan Administrator shall have the authority to accept data provided by the Associated Entity, unless the Plan Administrator deems such data to be inaccurate or incomplete.

(j) Nothing contained in this definition of Hour of Service shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States or any rule or regulation promulgated under any such law; nor as denying an Employee credit for an Hour of Service if credit is required by separate Federal law.

**2.15 Participant** means any former Employee who has terminated from all Associated Entities and who participates under Article 6 of the Plan.

**2.16 Plan** means the Ascension Health Retirement Health Reimbursement Arrangement, as set forth herein, and any and all amendments and supplements thereto.
2.17 **Plan Administrator** means Ascension Health or such other person or committee as may be appointed from time to time by Ascension Health to supervise the administration of the Plan.

2.18 **Plan Year** means the calendar year.

2.19 **Qualifying Medical Expenses** means any expense eligible for reimbursement under the Plan which would qualify as a "medical care" expense (within the meaning of Code Section 213(d) and as allowed under Code Section 105 and the rulings and Treasury regulations thereunder) of the Participant. Notwithstanding the foregoing, a Participant may not be reimbursed for "qualified long-term care services" as defined in Code Section 7702B(c) or expenses which the Plan Administrator determines would violate the ethical and religious principles of Catholic health facilities, such as expenses relating to abortions or sterilizations. An expense is not a Qualifying Medical Expense if it is reimbursable under another health care plan. Any amounts received for Qualifying Medical Expenses may not be used by the Participant as a deduction in determining the Participant’s tax liability under the Code or be reimbursed under any other health coverage, including the a health flexible spending account.

(a) **Only Participant Expenses Eligible for Reimbursement.** Only expenses incurred by the Participant for whom the Benefits Account is maintained are Qualifying Medical Expenses eligible for reimbursement under the Plan. Expenses incurred by anyone who is a dependent and beneficiary of the Participant under another plan are not eligible for reimbursement under this Plan.

2.20 **Sponsor** means Ascension Health, a not-for-profit corporation organized under the laws of Missouri.

2.21 **Vesting Service** means the years which are credited to a Participant for the purpose of determining his vesting status and his entitlement to various benefits under the Plan. An Employee shall receive credit for Vesting Service for his period of employment by one or more Associated Entities, regardless of whether the Associated Entity or Associated Entities have adopted this Plan. A Participant’s total Vesting Service shall equal the sum of the Plan Years during which he is credited with at least one thousand (1,000) Hours of Service. Not more than one (1) year of Vesting Service shall be credited for any Plan Year in which an Employee is employed or reemployed by more than one Associated Entity.

(a) If an Associated Entity becomes an Employer, for purposes of determining the Vesting Service of an Employee of such Associated Entity, the Plan Administrator shall have the authority to accept data provided by the Associated Entity, unless the Plan Administrator deems such data to be inaccurate or incomplete.
ARTICLE 3. ELIGIBILITY

3.1 Eligibility to Receive Credits.

(a) Unless excluded pursuant to Sections 3.2 or 3.3, any Employee shall become an Eligible Individual who can receive Credits under this Plan as of the Entry Date of the Plan Year in which the Employee completes one thousand (1,000) or more Hours of Service.

(b) Notwithstanding anything contained herein to the contrary, an individual who is excluded from participation because he is classified by his employer as a leased employee or an independent contractor shall not be eligible to retroactively participate in this Plan and receive Credits or Vesting Service under this Plan if his employer or a court or administrative agency subsequently determines that the individual is a common law employee and not a leased employee or an independent contractor. If a leased employee or independent contractor is determined to be a common law employee, such individual shall become eligible for participation in accordance with Section 3.1(a), provided that for this purpose, such individual’s Entry Date shall be the date on which his or her reclassification as a common law employee was determined.

(c) Except as otherwise provided in the Plan, an Employee who meets the eligibility requirements of Section 3.1(a) but is excluded from participation pursuant to the provisions of Section 3.2 or Section 3.3 shall become an Eligible Individual on the Entry Date of his transfer from a unit of Employees not eligible to participate pursuant to Sections 3.2 or Section 3.3 to a classification of Employees eligible to participate.

3.2 Collective Bargaining Unit Employees. No Employee shall be an Eligible Individual in this Plan at any time during which the Employee is a member of a unit of individuals represented by a collective bargaining agent if benefits of the type provided for in this Plan were the subject of good faith bargaining, unless good faith negotiations between the Employer and the collective bargaining agent have resulted in a currently effective collective bargaining agreement which requires such Employee’s inclusion under the Plan as an Eligible Individual.
3.3 **Leased Employees.** Notwithstanding any other provisions of the Plan, no Employee shall be an Eligible Individual at any time while he is a leased employee within the meaning of Code Section 414(n)(2).

3.4 **Cessation of Eligible Individual Status.** An Eligible Individual shall cease to be an Eligible Individual as of the earliest of:

(a) the date on which the Plan terminates, or

(b) the date on which the Employee no longer meets the eligibility requirements of the Plan.

3.5 **Reinstatement of Former Eligible Individual.** A former Eligible Individual will become an Eligible Individual again if and when the Employee again meets the eligibility requirements of Section 3.1 and is not excluded from receiving Credits under Sections 3.2 or 3.3.

3.6 **Transferred Employees.** A transferred Employee is an Employee who has worked at multiple Associated Entities, of which at least one has adopted this Plan, regardless of any Breaks in Service that occur between the periods of employment by the Employers or Associated Entities. For purposes of determining the Hours of Service and Vesting Service of a transferred Employee under this Section 3.6, the Administrator shall have the authority to accept data provided by the transferring employer, unless the Administrator deems such data to be inaccurate or incomplete.
ARTICLE 4. CONTRIBUTIONS

4.1 Employer Contributions. Employer Contributions shall constitute Credits which shall be allocated to the Benefits Accounts of Eligible Individuals. The number of Employer-provided Credits to be allocated to Eligible Individuals’ Benefits Accounts per Plan Year shall be one thousand two hundred dollars ($1,200.00) for all Eligible Individuals who are credited with at least one thousand (1,000) Hours of Service during such Plan Year and who are still Employees on December 31 of such Plan Year, unless an Employee terminated before December 31 after reaching age 55 and after completing at least one thousand (1,000) Hours of Service or transferred before December 31 to another Associated Entity, regardless of whether that Associated Entity has adopted this Plan, after completing at least one thousand (1,000) Hours of Service with all Associated Entities during such Plan Year. Employer-provided Credits which are converted to cash shall not be taken into account for purposes of determining the Participant’s compensation-based benefits under any other pension or welfare benefit plan maintained by the Employer.

(a) Prior Service. No service with an Associated Entity shall be recognized for purposes of this Section 4.1 for an Employee prior to the Associated Entity’s Effective Date of participation.

(b) One Contribution. Not more than one thousand two hundred dollars ($1,200.00) shall be credited for any Plan Year in which an Employee is employed or reemployed by more than one Associated Entity.

4.2 No Participant Contributions. Contributions by an Eligible Individual or Participant under the Plan are neither required nor permitted.

4.3 Annual Increase in Benefits Account Balance. Benefits Accounts for all Employees shall be increased annually on December 31 prior to the addition of any Employer Contributions under Section 4.1 by the lesser of three percent (3%) or the annual rate of increase to index qualified plan limits under Code Section 415(d). No individual shall receive an increase to his Benefits Account under this Section 4.3 for any Plan Year unless such individual is an Employee as of December 31 of such Plan Year.
ARTICLE 5.  DETERMINATION OF VESTED BENEFITS

5.1 Vesting of Benefits.

(a) An Eligible Individual’s Benefits Account shall be one hundred percent (100%) vested upon such Eligible Individual’s attainment of age sixty-five (65), regardless of the Eligible Individual’s Vesting Service.

(b) An Eligible Individual’s Benefits Account shall be one hundred percent (100%) vested upon such Eligible Individual’s attainment of age fifty-five (55) and upon the Eligible Individual completing five (5) full years of Vesting Service.

(c) A Disabled Participant’s Benefits Account shall be one hundred percent (100%) vested on the date the Social Security Administration makes a determination of disability, regardless of the Disabled Participant’s age, provided the Disabled Participant has completed at least five (5) full years of Vesting Service.

5.2 Time of Forfeiture.

(a) Before Vesting and Termination. A non-vested Eligible Individual with less than five (5) years of Vesting Service who incurs five (5) consecutive one-year (1) Breaks in Service shall forfeit all Credits credited and shall forfeit all Vesting Service earned prior to such Breaks in Service. A non-vested Eligible Individual with five (5) or more years of Vesting Service who incurs five (5) consecutive one-year Breaks in Service, other than due to disability, shall forfeit the entire amount of his Benefits Account, but shall not forfeit his Vesting Service.

(b) After Vesting and Termination. A Participant’s estate may submit claims in accordance with Section 6.2 for expenses incurred prior to the Participant’s death. All unused Credits remaining thereafter in a deceased Participant’s Benefits Account shall be forfeited.
ARTICLE 6.  PAYMENT OF BENEFITS

6.1 Amount of Benefit. A Participant’s benefit shall consist of the vested amount of his Benefits Account as of the date immediately preceding his termination from employment plus any Employer Contributions and any annual increases made for the Plan Year in which the Participant terminated employment.

6.2 Submission of Claims for Benefits. A Participant may submit claims on such form as may be prescribed by and delivered to the Plan Administrator for the reimbursement of Qualifying Medical Expenses on or before the ninetieth (90th) day after the end of the Plan Year during which the Qualifying Medical Expenses upon which reimbursement is being claimed was incurred. Any such claims shall include all information and evidence that the Plan Administrator deems necessary to properly evaluate the merit of and to make any necessary determinations on a claim for benefits. The Plan Administrator may request any additional information necessary to evaluate a claim. Qualifying Medical Expenses reimbursed from the Plan must have been incurred after the Participant’s termination from employment with all Associated Entities. Qualifying Medical Expenses are considered incurred when the medical services are actually rendered. This Plan shall reimburse any expenses only after amounts in all other plans that could reimburse the expenses have been exhausted.

6.3 Timing and Frequency of Reimbursements. A Participant may submit a claim for reimbursement for all or any part his benefit at any time and from time to time after the date on which the Participant has a termination from employment with all Associated Entities. Eligible reimbursements will be made directly to the Participant as soon as administratively practicable after receipt of a Participant's request.

6.4 No In-Service Reimbursements. An Eligible Individual may not be reimbursed for any portion of the Credits in his Benefits Account prior to termination from employment with all Associated Entities. A Participant or a Disabled Participant who is rehired by an Associated Entity may not be reimbursed for any expenses incurred during his reemployment with an Associated Entity.
ARTICLE 7. ADMINISTRATION OF PLAN

7.1 Plan Administrator. The administration of the Plan shall be under the supervision of the Plan Administrator. The Plan Administrator will have full power to administer the Plan in all of its details, subject to applicable requirements of law. For this purpose, the Plan Administrator’s powers will include, but will not be limited to, the following discretionary authority, in addition to all other powers provided by this Plan:

(a) To make and enforce such rules and regulations as it deems necessary or proper for the efficient administration of the Plan;

(b) To interpret and construe the terms of the Plan, its interpretation thereof in good faith to be final and conclusive upon all persons claiming benefits under the Plan;

(c) To decide all questions concerning the Plan and to determine the eligibility of any person to participate in or receive benefits under the Plan;

(d) To appoint such agents, counsel, accountants, consultants and other persons as may be required to assist in administering the Plan; and

(e) To allocate and delegate its responsibilities under the Plan and to designate other persons to carry out any of its responsibilities under the Plan, any such action to be by written instrument and in accordance with the applicable requirements of law.

7.2 Claims Procedure. A Participant who is entitled to a benefit ("claimant") shall file a claim therefor on such form as may be prescribed by and delivered to the Plan Administrator.

(a) Written or electronic notice of the disposition of a claim shall be furnished to the claimant within ninety (90) days after receipt of the claim by the Plan Administrator unless special circumstances require an extension of time for processing for up to an additional ninety (90) days. If such an extension of time is taken, before the expiration of the initial ninety-day (90-day) period, the Plan Administrator shall inform
the claimant of the delay in writing, including the reasons therefor and the date by which the Plan Administrator expects to render its decision.

(b) If a claim is denied, the notice described in paragraph (a) shall set forth, in a manner calculated to be understood by the claimant:

(1) the specific reason or reasons for the denial,

(2) reference to the specific Plan provisions on which the denial is based,

(3) a description of any additional material or information necessary for the perfection of the claim and an explanation of why such material or information is necessary, and

(4) a description of the claim review procedures of Section 7.3 and the time limits applicable to such procedures.

7.3 Claims Review Procedures. Any claimant who has been denied a benefit by a decision of the Plan Administrator shall be entitled to review of the denial by filing with the Plan Administrator a written request for appeal of the denial. Such request, together with a written statement of the reasons why the claimant believes his claim should be allowed, shall be filed with the Plan Administrator no later than one hundred eighty (180) days after the claimant's receipt of the notification of denial of his claim.

(a) The claimant or his authorized representative shall have an opportunity to submit written comments, documents, records, and other information relating to the claim for benefits. Upon request by the claimant or his authorized representative, the Plan Administrator shall provide reasonable access to and copies of all documents, records, and other information relevant to the claimant's claim for benefits. Such copies shall be provided free of charge.

(b) The review shall take into account all comments, documents, records, and other information submitted by the claimant relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

(c) The Plan Administrator shall review the disputed claim and render a decision in writing not later than sixty (60) days after its receipt of a timely request for review unless special circumstances require an extension of time for processing for up to sixty (60) additional days. If such an extension of time is taken, the Plan Administrator shall notify the claimant in writing of the reasons for the extension.
Administrator shall inform the claimant of the delay in writing before the expiration of the initial sixty-day (60-day) period, including the date by which the Plan Administrator expects to render its decision.

(d) The Plan Administrator shall provide the claimant with written or electronic notification of the Plan Administrator’s decision on review. The decision on review shall be written in a manner calculated to be understood by the claimant and shall set forth

1. the specific reason or reasons for the decision;

2. reference to the specific Plan provisions on which the decision is based;

3. a statement that the claimant is entitled to receive reasonable access to and copies of all documents, records and other information relevant to the claimant’s claim for benefits. Such copies shall be provided free of charge, upon request.

7.4 **Nondiscrimination as to Benefits and Eligibility.**

(a) The Plan may not discrimination in favor of Highly Compensated Individuals as to benefits provided or as to eligibility to receive Credits or benefits.

(b) If the Plan Administrator determines, before or during any Plan Year, that the Plan may fail to satisfy any nondiscrimination requirement or any limitation on benefits provided to Highly Compensated Individual imposed by the Code, the Plan Administrator shall take such action as the Plan Administrator deems appropriate, under rules uniformly applicable to similarly situated Eligible Individuals to assure compliance with such requirement or limitation.

7.5 **Examination of Records.** The Plan Administrator shall make available to each Eligible Individual or Participant such of its records under the Plan as pertain to him, for examination at reasonable times during normal business hours.

7.6 **Nondiscriminatory Exercise of Authority.** In the administration of the Plan, whenever any discretionary action by the Plan Administrator is required, the Plan Administrator shall exercise its authority in a nondiscriminatory manner in order that all persons similarly situated will receive substantially the same treatment.

7.7 **Indemnification of Plan Administrator.** The Employer agrees to indemnify and to defend to the fullest extent permitted by law any Employee serving as
the Plan Administrator or as a member of a committee designated as Plan Administrator (including any Employee or former Employee who formerly served as Plan Administrator or as a member of such committee) and any Employee acting on behalf of the Employer as Plan Administrator against all liabilities, damages, costs, and expenses (including attorneys’ fees specifically authorized by the Employer and amounts paid in settlement of any claims approved by the Employer) occasioned by any good faith act or omission in connection with the Plan.

7.8 Expenses. With respect to its own Employees, each Employer shall bear all costs and expenses associated with this Plan, except that administrative fees or expenses associated with the Plan may be passed through to Participants.
ARTICLE 8. USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

8.1 Definitions. For purposes of this Article 8, the following words shall have the meanings set forth below:

(a) Covered Entity: An entity subject to the regulations enacted under the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), including health care providers who transmit health information in an electronic form, health plans, and health care clearinghouses. The Plan is a Covered Entity.

(b) Health Care Operations: Activities that include, but are not limited to, any of the following activities of the Plan to the extent that the activities are related to Plan functions:

(1) Conducting quality assessment and improvement activities;

(2) Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, contacting health care providers and patients with information about treatment alternatives, and related functions that do not include treatment;

(3) Reviewing the competence of health care professionals and their performance, including accreditation, certification, licensing, or credentialing activities;

(4) Underwriting, premium rating, and other activities related to the creation, renewal, or replacement of a contract of health insurance or health benefits, and surrendering, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess loss insurance);

(5) Conducting or arranging medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
(6) Business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement methods of payment or coverage policies; and

(7) Business management and general administrative activities of the Plan, such as

(A) management activities relating to implementation of and compliance with HIPAA's administrative simplification requirements;

(B) customer service, including provision of data analysis for policy holders, plan sponsors, or other customers, provided that PHI is not disclosed to such policy holder, plan sponsor, or customer;

(C) resolution of internal grievances; and

(D) due diligence related to the sale, transfer, merger of the Plan to, or consolidation of all or part of the Plan with another Covered Entity, or an entity that following such activity will become a Covered Entity.

(c) HIPAA: The Health Insurance Portability and Accountability Act of 1996, as it may be amended from time to time.

(d) Individually Identifiable Health Information: Information that is a subset of health information, including demographic information collected from an individual, and:

(1) That is created or received by a health care provider, health plan, employer, or health care clearinghouse, and

(2) That relates to the past, present, or future physical or mental health or condition of a Participant; the provision of health care to a Participant; or the past, present, or future payment for the provision of health care to a Participant; and

(A) That identifies the Participant; or

(B) With respect to which there is a reasonable basis to believe the information can be used to identify the Participant.
(e) **Organized Health Care Arrangement:** A group health plan and one or more other group health plans which are maintained by the same plan sponsor; and health insurance issuers or HMOs with respect to such group health plans, but only with respect to PHI created or received by such health insurance issuers or HMOs that relates to individuals who are or have been Participants or beneficiaries of such group health plans.

(f) **Payment:** The activities undertaken by the Plan to determine or fulfill the Plan's responsibility for coverage and provision of benefits. These activities relate to the Participant to whom health care is provided. They include, but are not limited to:

1. Determinations of eligibility or coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;

2. Risk adjusting amounts due based on Participant health status and demographic characteristics;

3. Billing, claims management, collection activities, obtaining payment under a contract for reinsurance (including stop-loss insurance and excess loss insurance), and related health care data processing;

4. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;

5. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and

6. Disclosure to consumer reporting agencies of any of the following PHI relating to collection of premiums or reimbursement:

   (A) name and address;

   (B) date of birth;

   (C) social security number;

   (D) payment history;
(E) account number; and

(F) name and address of the health care provider and/or health plan.

(g) **Protected Health Information ("PHI")**: Individually Identifiable Health Information that is transmitted or maintained in any form or medium. PHI does not include educational records covered by the Family Educational Rights and Privacy Act or employment records held by a Covered Entity in its role as employer.

(h) **Regulations**: The Standards for Privacy of Individually Identifiable Health Information enacted in accordance with HIPAA at 45 Code of Federal Regulations (CFR) Parts 160 and 164, as amended from time to time.

(i) **Secretary**: The Secretary of the Department of Health and Human Services.

(j) **Treatment**: The coordination or management of health care and related services by one or more health care providers, the coordination or management of health care by a health care provider and a third party, consultation between health care providers relating to a patient, or the referral of a patient for health care from health care provider to another.

8.2 **General Provisions.** The Plan will use PHI to the extent of and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose PHI for purposes related to Treatment, Payment, and Health Care Operations.

8.3 **Use and Disclosure of PHI as Required by Law.** The Plan will use and disclose PHI as required by federal and state law, including uses and disclosures required by the Secretary to investigate or determine the Plan’s compliance with privacy regulations.

8.4 **Use and Disclosure of PHI as Permitted by Authorization of a Participant.** The Plan will disclose a Participant’s PHI to the Employer for the purpose of administering employee benefit plans that are not Covered Entities only with an authorization from the Participant.
8.5 **Duties of Employer.** The Employer agrees to:

(a) not use or further disclose PHI other than as permitted or required by the Plan document or as required by law;

(b) ensure that any agents, including a subcontractor, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

(c) not use or disclose PHI for employment-related actions and decisions unless authorized by a Participant;

(d) not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer, other than (if otherwise permissible under applicable state law) a health plan that is part of an Organized Health Care Arrangement which includes the Plan, unless authorized by a Participant;

(e) report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for herein of which it becomes aware;

(f) make PHI available to a Participant in accordance with HIPAA’s access requirements;

(g) make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA;

(h) make available the information required to provide an accounting of disclosures;

(i) make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the Secretary for the purpose of determining the Plan’s compliance with HIPAA; and

(j) if feasible, return or destroy all PHI received from the Plan that the Employer still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible).

8.6 **Separation Between Plan and Employer.** In accordance with HIPAA, only the following employees or classes of employees may be given access to PHI:
(a) employees in the Human Resources Department of an Employer;

(b) employees in the Accounting Department of an Employer;

(c) employees in the Compensation & Benefits Department of an Employer; and

(d) employees of an Employer otherwise authorized by the Plan Administrator to receive, use, and disclose PHI for plan administration purposes.

8.7 Limitations of PHI Access and Disclosure. The persons described in the paragraph above entitled Separation Between Plan and Employer may only have access to and use and disclose PHI for plan administrative functions that the Employer performs for the Plan.

8.8 Noncompliance Issues. If the persons described in Section 8.6 do not comply with this Plan, the Employer shall provide a mechanism for resolving issues of noncompliance, including disciplinary sanctions.

8.9 HIPAA Security Requirements.

(a) Implementation of Safeguards. The Sponsor will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the electronic PHI that Sponsor creates, receives, maintains, or transmits on behalf of the Plan ("ePHI") as required by Subpart C of 45 C.F.R. Part 164 (25 C.F.R. 164.302 through 164.318).

(b) Security Measures to Support Adequate Separation Requirements. The Sponsor will ensure that the provisions of Sections 8.6, 8.7 and 8.8 are supported by reasonable and appropriate security measures.

(c) Agents and Subcontractors. The Sponsor agrees to ensure that any agent, including a subcontractor, to whom it provides ePHI agrees to implement reasonable and appropriate safeguards to protect ePHI.

(d) Reporting of Security Incidents. The Sponsor will report to the Plan any security incident involving ePHI of which the Sponsor becomes aware.

(e) Definitions: For purposes of this Section 8.9, the following definitions shall apply:
(1) **Administrative safeguards:** Administrative safeguards are administrative actions, and policies and procedures, to manage the selection, development, implementation, and maintenance of security measures to protect ePHI and to manage the conduct of the workforce in relation to the protection of that information.

(2) **Physical safeguards:** Physical safeguards are physical measures, policies, and procedures to protect electronic information systems and related buildings and equipment from natural and environmental hazards and unauthorized intrusion.

(3) **Technical safeguards:** Technical safeguards means the technology and the policy and procedures for its use that protect ePHI and control access to it.

(4) **Confidentiality:** Confidentiality means the property that data or information is not made available or disclosed to unauthorized persons or processes.

(5) **Integrity:** Integrity means that data or information has not been altered or destroyed in an unauthorized manner.

(6) **Availability:** Availability means the property that data or information is accessible and useable upon demand by an authorized person.

(7) **Security incident:** Security incident means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.
ARTICLE 9. AMENDMENT AND TERMINATION OF PLAN

9.1 Amendment of Plan. This Plan may be amended at any time, to any extent and in any manner as the Sponsor may deem advisable, by a written instrument signed by an authorized officer thereof. Any such amendment to the Plan shall be immediately binding upon and effective with respect to the Employer, and the Employer shall be deemed to have assented to any such amendment.

9.2 Termination of Plan. The Sponsor may terminate or discontinue this Plan on behalf of any Employer and any Employer may terminate or discontinue its status as an Employer under this Plan at any time by a written instrument signed by an authorized officer of the Sponsor or an officer of the Employer, as the case may be.
ARTICLE 10. MISCELLANEOUS PROVISIONS

10.1 Information to Be Furnished. Eligible Individuals shall provide their Employer and the Plan Administrator with such information and evidence and shall sign such documents as may reasonably be requested from time to time for the purpose of administering the Plan.

10.2 Limitation of Rights. Neither the establishment of the Plan, nor any amendment thereof, nor the payment of any benefits will be construed as giving to any Participant or other person any legal or equitable right against the Employer or Plan Administrator or their respective officers and directors, as an Employee or otherwise, except as provided herein, and in no event will the terms of employment or service of any Participant or Employee be modified or in any way affected hereby.

10.3 Severability. If any provision of this Plan is held invalid, unenforceable or inconsistent with the requirements for a health reimbursement arrangement, its invalidity, unenforceability or inconsistency shall not affect any other provision of the Plan, and the Plan shall be construed and enforced as if such provision were not a part of this Plan.

10.4 Construction of Terms. Words of gender shall include persons and entities of any gender, the plural shall include the singular and the singular shall include the plural. Section headings exist for reference purposes only and shall not be construed as part of the Plan.

10.5 Governing Law. To the extent not pre-empted by the Employee Retirement Income Security Act of 1974, this Plan shall be construed, administered and enforced according to the laws of and in courts situated in the state of Missouri.

10.6 Retiree-Only Plan. For purposes of the Patient Protection and Affordable Care Act ("PPACA"), this Plan is considered a retiree-only plan which covers less than two employees who are current employees.
IN WITNESS WHEREOF, Ascension Health has caused this Plan to be executed in its name and on its behalf effective as of the 1st day of January, 2013, by its officer thereunto duly authorized.

ASCENSION HEALTH

By: Eric Demotein

Title: VP, Compensation & Benefits
ATTACHMENT 1

ST. MARY’S HEALTHCARE
AMSTERDAM, NY
EIN: 14-1794727

SETON HEALTHCARE
AUSTIN, TEXAS
EIN: 74-1109643

SETON MEDICAL GROUP, INC.
BALTIMORE, MARYLAND
EIN: 39-2064992

ST. AGNES HEALTHCARE, INC.
BALTIMORE, MARYLAND
EIN: 52-0591657

OUR LADY OF LOURDES MEMORIAL HOSPITAL, INC.
BINGHAMTON, NY
EIN: 15-0532221

ST. VINCENT’S HEALTH SYSTEM
BIRMINGHAM, AL
EIN: 63-0931008

ST. VINCENT’S HOSPITAL
BIRMINGHAM, AL
EIN: 63-0288864

UNIVERSAL HEALTH SERVICES
BIRMINGHAM, AL
EIN: 63-0932323

HALL-BROOKE BEHAVIORAL HEALTH SERVICES, INC.
BRIDGEPORT (WESTPORT), CT
EIN: 06-0813283

ST. VINCENT’S COLLEGE, INC.
BRIDGEPORT, CT
EIN: 06-1331677

ST. VINCENT’S MEDICAL CENTER
BRIDGEPORT, CT
EIN: 06-0813283

ST. VINCENT’S MULTISPECIALTY GROUP, INC.
BRIDGEPORT, CT
EIN: 80-0458769
ST. VINCENT’S SPECIAL NEEDS CENTER, INC.
BRIDGEPORT (TRUMBULL), CT
EIN: 06-0702617

CENTRO SAN VICENTE
EL PASO, TX
EIN: 74-2505561

NAZARETH HALL
EL PASO, TX
EIN: 74-2387843

PHYSICIAN HEALTH GROUP, LLC
EVANSVILLE, IN
EIN: 04-3679294

PRIMARY PHYSICIAN NETWORK, LLC
EVANSVILLE, IN
EIN: 20-8775914

ST. MARY’S AT HOME, INC.
EVANSVILLE, IN
EIN: 35-1899560

ST. MARY’S BREAST CENTER
EVANSVILLE, IN
EIN: 35-1935526

ST. MARY’S HEALTH SYSTEM OF AMERICA, INC.
EVANSVILLE, IN
EIN: 35-2057801

ST. MARY’S HOME HEALTH CARE SERVICES, INC.
EVANSVILLE, IN
EIN: 35-1899562

ST. MARY’S MEDICAL CENTER OF EVANSVILLE, INC.
EVANSVILLE, IN
EIN: 35-0869065

ST. MARY’S OHIO VALLEY HEARTCARE, LLC
EVANSVILLE, IN
EIN: 27-3474697

ST. MARY’S PHYSICIAN HEALTH GROUP, LLC
EVANSVILLE, IN
EIN: 26-1356310

ST. MARY’S PHYSICIAN NETWORK, LLC
EVANSVILLE, IN
EIN: 20-5023387
ST. VINCENT MADISON COUNTY HEALTH SYSTEM, INC.
D/B/A SAINT JOHN’S HEALTH SYSTEM (ANDERSON, IN) and
ST. VINCENT MERCY HOSPITAL (ELWOOD, IN)
INDIANAPOLIS, INDIANA
EIN: 35-0876389

ST. VINCENT MEDICAL GROUP, INC.
INDIANAPOLIS, INDIANA
EIN: 27-2030417

ST. VINCENT NEW HOPE, INC.
INDIANAPOLIS, INDIANA
EIN: 35-1733591

ST. VINCENT PEDIATRIC REHABILITATION CENTER, INC.
INDIANAPOLIS, INDIANA
EIN: 35-2048898

ST. VINCENT PHYSICIAN NETWORK, LLC
INDIANAPOLIS, INDIANA
EIN: 20-1338729

ST. VINCENT RANDOLPH HOSPITAL, INC.
INDIANAPOLIS (WINCHESTER), INDIANA
EIN: 35-2103153

ST. VINCENT SALEM HOSPITAL, INC.
INDIANAPOLIS (Salem), INDIANA
EIN: 27-0847538

ST. VINCENT WILLIAMSPORT HOSPITAL, INC.
INDIANAPOLIS (WILLIAMSPORT), INDIANA
EIN: 35-0784551

ST. VINCENT HEART CENTER OF INDIANA, LLC
INDIANAPOLIS, INDIANA
EIN: 36-4492612

CONSOLIDATED PHARMACY SERVICES, INC.
JACKSONVILLE, FL
EIN: 59-3398033

ST. LUKE’S – ST. VINCENT’S HEALTHCARE, INC.
JACKSONVILLE, FL
EIN: 26-0479484

ST. VINCENT’S FOUNDATION, INC.
JACKSONVILLE, FL
EIN: 59-2219923
ST. VINCENT’S HEALTHCARE
JACKSONVILLE, FL
EIN: 59-3650609

ST. VINCENT’S MEDICAL CENTER, INC.
JACKSONVILLE, FL
EIN: 59-0624449

CARONDELET HEALTH
KANSAS CITY, MO
EIN: 43-1276738

CARONDELET HOME CARE SERVICES, INC.
KANSAS CITY, MO (OVERLAND PARK, KS)
EIN: 43-1379352

CARONDELET MANAGEMENT COMPANY, INC.
KANSAS CITY, MO
EIN: 43-1352545

CARONDELET OCCUPATIONAL HEALTH, WELLNESS AND EDUCATIONAL SERVICES, INC.
KANSAS CITY, MO
EIN: 86-1144194

CARONDELET PHARMACY AT SAINT JOSEPH HEALTH CENTER, INC.
KANSAS CITY, MO
EIN: 43-1699329

CARONDELET PHYSICIAN SERVICES, INC.
KANSAS CITY, MO
EIN: 56-26611163

ST. JOSEPH MEDICAL CENTER
KANSAS CITY, MO
EIN: 44-0546292

ST. JOSEPH MEDICAL CENTER FOUNDATION
KANSAS CITY, MO
EIN: 43-1388461

ST. MARY’S MEDICAL CENTER
KANSAS CITY, MO
EIN: 43-1284526

SETON CENTER, INC.
KANSAS CITY, MO
EIN: 43-0926003
ST. JOSEPH REGIONAL MEDICAL CENTER, INC.
LEWISTON, IDAHO
EIN: 82-0204264

MOUNT ST. MARY’S HOSPITAL OF NIAGARA FALLS
LEWISTON, NEW YORK
EIN: 16-1523353

COLUMBIA COLLEGE OF NURSING, INC.
MILWAUKEE, WI
EIN: 39-1596986

COLUMBIA*ST. MARY’S COLUMBIA CAMPUS
MILWAUKEE, WI
EIN: 39-0806204

SACRED HEART REHABILITATION INSTITUTE, INC.
MILWAUKEE, WI
EIN: 39-0902199

SETON CHILDREN’S SCHOOL, INC.
D/B/A CSM CHILDREN’S SCHOOL
MILWAUKEE, WI
EIN: 39-1391245

COLUMBIA ST. MARY’S HOSPITAL MILWAUKEE, INC.
D/B/A COLUMBIA*ST. MARY’S MILWAUKEE CAMPUS
MILWAUKEE, WI
EIN: 39-0806315

COLUMBIA ST. MARY’S HOSPITAL MILWAUKEE, INC.
D/B/A COLUMBIA*ST. MARY’S MILWAUKEE CAMPUS
MILWAUKEE, WI
EIN: 39-0806315

ST. MARY’S HOSPITAL OZAUKEE, INC.
D/B/A COLUMBIA*ST. MARY’S OZAUKEE CAMPUS
D/B/A THE GLENDALE CLINICS,
MILWAUKEE, WI
EIN: 39-0807063

MISSISSIPPI PROVIDENCE HEALTHCARE SERVICES, INC
MOBILE, AL (MOSS POINT, MS)
EIN: 46-1130426
PROVIDENCE HEALTHCARE SERVICES
MOBILE, AL
EIN: 63-0937705

PROVIDENCE HOSPITAL
MOBILE, AL
EIN: 63-0288861
SETON MEDICAL MANAGEMENT, INC.
MOBILE, AL
EIN: 63-0937704

BAPTIST HEALTH CARE AFFILIATES, INC.
NASHVILLE, TN
EIN: 58-1509251

BAPTIST HEALTH CARE GROUP
NASHVILLE, TN
EIN: 62-1529858

BAPTIST HEALTH CARE GROUP
NASHVILLE, TN
EIN: 62-1529858

BELLEVUE MEDICAL GROUP, LLC
NASHVILLE, TN
EIN: 62-1868848

HICKMAN COMMUNITY HEALTH CARE SERVICES, INC.
NASHVILLE (CENTERVILLE), TN
EIN: 58-1737573

MIDDLE TENNESSEE MEDICAL CENTER, INC.
NASHVILLE, TN
EIN: 62-0475842

RICHLAND INTERNAL MEDICINE, LLC
NASHVILLE, TN
EIN: 62-1868762

SETON CORPORATION
(D/B/A BAPTIST HOSPITAL)
NASHVILLE, TN
EIN: 62-1869474

SAINT THOMAS EMERGENCY MEDICAL SERVICES, LLC
NASHVILLE, TN
EIN: 20-8957092

SAINT THOMAS HEALTH
NASHVILLE, TN
EIN: 58-1716804

SAINT THOMAS HOSPITAL
NASHVILLE, TN
EIN: 62-0347580
SAINT THOMAS NETWORK
NASHVILLE, TN
EIN: 62-1284994

SAINT THOMAS RESEARCH INSTITUTE, LLC
Nashville, Tennessee
EIN: 20-8018726

SOVA, INC.
NASHVILLE, TN
EIN: 26-131938

STHS HEART, LLC
NASHVILLE, TN
EIN: 20-5753931

MISSIONPOINT HEALTH PARTNERS
NASHVILLE, TN
EIN: 45-2958482

DAUGHTERS OF CHARITY SERVICES OF NEW ORLEANS
NEW ORLEANS, LA
EIN: 72-1332678

SACRED HEART HEALTH SYSTEM, INC.
PENSACOLA, FL
EIN: 59-0634434

ST. MARY’S OF MICHIGAN
SAGINAW, MI
EIN: 38-0997730

STANDISH COMMUNITY HOSPITAL, INC.
STANDISH, MI
EIN: 38-1671120

DAUGHTERS OF CHARITY SERVICES OF SAN ANTONIO
SAN ANTONIO, TX
EIN: 17-461068763

ASCENSION HEALTH ALLIANCE
ST. LOUIS, MO
EIN: 45-3358926

ASCENSION HEALTH
ST. LOUIS, MO
EIN: 31-1662309

ASCENSION HEALTH-IS, INC.
ST. LOUIS, MO
EIN: 65-1257719
BRIGHTON HOSPITAL
WARREN, MI
EIN: 38-1576680

EASTWOOD COMMUNITY CLINICS
WARREN, MI
EIN: 38-1958763

MEDICAL RESOURCE GROUP
WARREN, MI
EIN: 38-3494637

PROVIDENCE HOSPITAL & MEDICAL CENTER
WARREN, MI
EIN: 38-1358212

SARATOGA NURSING CENTER
D/B/A FATHER MURRAY NURSING CENTER
WARREN, MI
EIN: 38-2601348

ST. JOHN COMMUNITY HEALTH INVESTMENT CORPORATION
WARREN, MI
EIN: 38-2262856

ST. JOHN HEALTH
WARREN, MI
EIN: 38-2244034

ST. JOHN HEALTH FOUNDATION
WARREN, MI
EIN: 38-2769385

ST. JOHN HOME CARE
D/B/A REVERENCE HOME HEALTH & HOSPICE
WARREN, MI
EIN: 38-3408684

ST. JOHN HOSPITAL & MEDICAL CENTER
D/B/A ST. JOHN NORTH SHORES HOSPITAL
WARREN, MI
EIN: 38-1359063

ST. JOHN MACOMB-OAKLAND HOSPITAL
WARREN, MI
EIN: 38-3322109

ST. JOHN RIVER DISTRICT HOSPITAL
WARREN, MI
EIN: 38-3160564