Southcoast® Health Plan

Medicare Supplement Plan 2

Summary Plan Description

Effective: January 1, 2011
Restated as of: January 1, 2019

www.Southcoasthealthplan.org

HealthPlans, Inc.

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SOUTHCOAST HOSPITALS GROUP, INC.
MEDICARE SUPPLEMENT PLAN 2
AMENDMENT #1 TO THE
RESTATED JANUARY 1, 2019 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2020

This Plan is amended to update the Case Management Services provider address. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION II. GENERAL INFORMATION, Case Management Services is hereby **deleted** and **replaced** in its entirety as follows:

Case Management Services:	Conifer Value-Based Care, LLC (hereafter referred to as "Conifer") 7624 Warren Parkway Frisco, TX 75034 (877) 234-5550

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP
MEDICAL BENEFIT PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS

The Medical Benefit Plan(s) offered by Southcoast Hospitals Group, Inc. and administered by Health Plans, Inc. are amended to include coverage related to the testing and treatment of COVID-19 described below, as well as to include continued coverage under the Plan(s), in accordance with the terms of the Coronavirus Aid, Relief, and Economic Stimulus (CARES) Act. The provisions below are in addition to and supersede any contrary provisions detailed in the Plan Document(s) and/or Summary Plan Descriptions.

The Plan(s) are hereby amended to include the provisions below, effective as of the date specified for each provision. :

Coverage for the testing and diagnosis of COVID-19 includes the following:

- Coverage of testing authorized under federal law and diagnosis for COVID-19 without any cost sharing (e.g. deductibles, copayments or coinsurance) or prior authorization or other medical management requirements. This includes in- and out-of-network telehealth visits, office visits, ER visits and urgent care visits related to determining the need for a test or the actual test, and any related medical services during that time**. Effective March 18, 2020**
- Payment to testing providers according to the network contracted rate. In the absence of a negotiated rate for out-of-network providers, payment will be based on the price posted on the provider's web site**. Effective March 18, 2020.**

Coverage for the treatment and prevention of COVID-19 includes the following:

- Coverage of COVID-19 treatment services received via telehealth services or as outpatient services with cost sharing waived. **Effective March 18, 2020**
- Coverage of COVID-19 preventive care and/or vaccinations that may become available with cost sharing waived within 15 days of recommendation for such services issued by either the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. **Effective March 27, 2020.**

Note: Coverage for inpatient treatment of COVID-19 continues under the same terms of the Plan(s) applicable to inpatient treatment for other illnesses or injuries.

Coverage for non-COVID-19 related health care services provided via telehealth

- All Plans except any Employer Qualified High Deductible Health Plans (QHDHPs), will cover non-COVID-19-related health care services provided via telehealth providers with no member cost sharing. **Effective March 18, 2020.**

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP
HEALTH AND WELFARE BENEFIT PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS
EFFECTIVE MARCH 1, 2020

The Health and Welfare Benefit Plans regulated under the Employee Retirement Income Security Act (ERISA) which are offered by the Employer named above and administered by Health Plans, Inc. are hereby amended to extend certain timeframes affecting COBRA continuation coverage, special enrollment periods, claims for benefits, appeals of denied claims, and external review of certain claims to be in compliance with the requirements of the regulations promulgated under 29 CFR Part 54 and 29 CRF Parts 2560 and 2590, Extension of Certain Timeframes for Employee Benefit Plans, Participants and Beneficiaries Affected by the COVID-19 Outbreak, published on Monday, May 4, 2020, in the Federal Register, Volume 85, No. 86, page 26352.

Such extension of timeframes will apply only until the date(s) described in the regulation or any subsequently issued related statute, regulation or regulatory guidance.

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I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by Southcoast Hospitals Group, Inc. (hereinafter the "Employer") on this 1st day of January, 2019 sets forth the Southcoast Hospitals Group, Inc. Medicare Supplement Plan 2 effective as of January 1, 2019.

A. Establishment of Plan

The Employer hereby sets forth its group health plan known as the Southcoast Hospitals Group, Inc. Medicare Supplement Plan 2 (the "Plan"). The Plan is written for the sole and exclusive purpose of providing to the Eligible Retirees medical benefits as described herein. These benefits have been established by your Employer and are provided on a self-funded basis. As such, the benefits are directly funded through and provided by your Employer, and your Employer has the sole responsibility and liability for payment of benefits under this Plan. Health Plans, Inc. is not the issuer, insurer, or provider of your benefits.

B. Effective Date

The Plan was originally effective as of January 1, 2011, and is hereby restated as of January 1, 2019.

C. Applicable Law

This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

The Plan is subject to all of the conditions and provisions set forth in this document and subsequent amendments which are made a part of this Plan.

Important Notice: To obtain a list of In-Network Providers under this Plan, please visit www.southcoasthealthplan.org to search the online provider directory or call the Health Plans, Inc. Customer Service Department at (877) 234-5550 for additional information.

Please Note: Physicians and other medical professionals in the Plan's provider network participate through contractual arrangements that can be terminated either by a provider or by the Network administrator. In addition, a provider may leave the network because of retirement, relocation or other reasons. Therefore, it is not a guarantee that a provider will always be included in the list of In-Network Providers.

II. GENERAL INFORMATION

Plan Name:	Southcoast Hospitals Group, Inc. Medicare Supplement Plan 2
Type of Plan:	Welfare plan providing medical benefits on a self-funded basis
Effective Date:	January 1, 2011, restated as of January 1, 2019
Employer/Plan Sponsor:	Southcoast Hospitals Group, Inc. (the "Employer") 101 Page Street New Bedford, MA 02740-3464 (508) 997-1515
ERISA Plan Number:	603
Employer Identification Number:	22-2592333
Group Number:	006SHP
Plan Administrator:	Employer (see above)
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (877) 234-5550
Case Management Services:	Conifer Value-Based Care, LLC (hereafter referred to as "Conifer") 1596 Whitehall Road Annapolis, MD 21409 (877) 234-5550
Agent for Service of Legal Process:	Employer (see above)
Plan Cost:	Contributory for former employees who were hired prior to January 1, 1993 to work at St. Luke's Hospital, who retired on or after January 1, 1993, who worked for St. Luke's Hospital and/or any Southcoast Health System, Inc. affiliate at least 20 years after reaching age 40, and who are otherwise eligible to enroll in this Plan. Per retirement agreement for all other former employees who are eligible to enroll in this Plan.

ERISA Plan Year Ends:	December 31st
Fiscal Year Ends:	September 30th
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized Officer of the Employer. Your consent is not required to terminate or change the Plan. Coverage otherwise ends as described in Article X. Termination and Continuation of Coverage. Contact the Plan Administrator to discuss what benefit extensions may apply or what arrangements may be made to continue coverage. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to an Employee's or his or her dependents' eligibility for coverage under the Plan, b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, an Employee may be responsible for any benefit payments made during the relevant period. For any rescission (retroactive termination of coverage that is related to fraud or intentional misrepresentation) the Plan Administrator will provide thirty (30) days advance written notice and an Employee will have the right to appeal the Plan's termination of coverage.

III. DEFINITIONS

The following words and phrases will have the following meanings when used in the Plan, unless a different meaning is plainly required by the context.

Calendar Year – the time period beginning January1st and ending December 31st

Coinsurance – the percentage of coverage provided by Medicare or the Plan for a covered service, after any applicable Deductible or Co-payment. For example, if Coinsurance is 70%, Medicare or the Plan pays 70% and 30% is due, after any applicable Deductible or Co-payment.

Co-payment – a fixed dollar amount a Covered Person pays for a covered service before any applicable Deductible or Coinsurance amount is applied, or as specified on the Schedule of Medical Benefits

Covered Person – a Retiree who is eligible for benefits and enrolled under this Plan.

Covered Services – the products and services that a Covered Person is eligible to receive, or obtain payment for, under this Plan as specifically set forth in the Medical Benefits section C. Covered Services.

Custodial Care – services designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be Custodial Care whenever and wherever furnished, without respect to the practitioner or provider by whom or by which they are prescribed, recommended or performed.

Deductible– the amount payable by a Covered Person for covered services before Medicare's share of the cost is determined.

Emergency Care – care administered in a hospital, clinic, or doctor's office for a Medical Emergency. Emergency Care does not include ambulance service to the facility where treatment is received.

ERISA – the Employee Retirement Income Security Act of 1974 as amended from time to time.

Expense Incurred Date – for the purposes of this Plan, the date a service or supply to which it relates is provided. If a Covered Person's claim relates to an Inpatient stay, the Expense Incurred Date is the date the Covered Person Inpatient stay ends.

Experimental/Investigational – a drug, device, medical treatment, new technology, procedure or supply which is not recognized as eligible for coverage as defined below

(1) The drug cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug, device, treatment, new technology, procedure or supply is furnished, or

(2) The drug, device, medical treatment, new technology, procedure or supply, or the patient's informed consent document utilized with the drug, device, treatment, new technology, procedure or supply, was reviewed and approved by the treating facility's institutional review board or other body serving a similar function, or if federal law requires such review or approval, or

(3) Reliable evidence shows that the drug, device, medical treatment, new technology, procedure or supply is the subject of on-going phase I or phase II clinical trials, is the research, experimental study or investigational arm of on-going phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis, except for drugs, devices, medical treatments, technology, procedures or supplies that would otherwise be covered under this Plan if they are provided to a Covered Person enrolled in a clinical trial, are consistent with that standard of care for someone with the patient's diagnosis, are consistent with the study protocol for the clinical trial and would be covered if the patient did not participate in the clinical trial; or

(4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

Reliable evidence will mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment, new technology, procedure or supply.

Home Health/Hospice Agency – an agency or organization which fully meets each of the following requirements:

(1) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.

(2) It has policies established by a professional group associated with the agency or organization, the professional group must include at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or required licensed or Registered Nurse.

(3) It maintains a complete medical record on each patient.

(4) It has an administrator.

Hospice Plan of Care – a prearranged, written outline of care for the palliation and management of a person's terminal illness.

Hospital – a licensed facility which:

(1) Furnishes room and board;

(2) Is primarily engaged in providing, on an inpatient basis, diagnostic and therapeutic facilities for the surgical and medical diagnosis, treatment and care of injured and sick persons by or under the supervision of doctors who are legally licensed to practice medicine;

(3) Regularly and continuously provide day and night nursing service by or under the supervision of a Physician;

(4) Is not, other than incidentally, a place for the aged or a nursing or convalescent home; and

(5) Is operated in accordance with the laws of the jurisdiction in which it is located pertaining to institutions identified as Hospitals.

The term "Hospital" will include a facility specializing in the care and treatment for rehabilitation and mental or emotional Illness, disorder or disturbance, which would qualify under this definition as a Hospital. The term "Hospital" will include a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.

Illness – a sickness or bodily disorder or disease, or mental health disease or disorder. An Illness due to causes which are the same or related to causes of a prior Illness, from which there has not been complete recovery will be considered a continuation of such prior Illness. The term "Illness" as used in this Plan will include pregnancy, childbirth, miscarriage, termination of pregnancy and any complications of pregnancy and related medical conditions.

Injury – a sudden event from an external agent resulting in damages to the physical structure of the body independent of Illness, and all complications arising from such external agent.

Inpatient Hospice Facility – a licensed facility which may or may not be part of a Hospital and which:

(1) Complies with licensing and other legal requirements in the jurisdiction where it is located;

(2) Is mainly engaged in providing inpatient palliative care for the terminally ill on a 24-hour basis under the supervision of a Physician or a Registered Nurse, if the care is not supervised by a Physician available on a prearranged basis;

(3) Provides pre-death and bereavement counseling;

(4) Maintains clinical records on all terminally ill persons; and

(5) Is not mainly a place for the aged or a nursing or convalescent home

Inpatient Hospice Facility also will include a hospice facility approved for a payment of Medicare hospice benefits.

Intensive Outpatient Treatment – mental health or substance abuse care on an individual or group basis two (2) to five (5) days per week for two (2) to three(3) hours per day in a licensed hospital, rural health center, community mental health center or substance abuse treatment facility.

Medical Emergency – The sudden onset of a medical condition of sufficient severity that an individual possessing an average knowledge of health and medicine could reasonably expect that failure to obtain medical treatment would seriously jeopardize the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child); or cause serious harm to bodily functions or any bodily organ or part. Examples of medical emergencies include symptoms of heart attack and stroke; poisoning; loss of consciousness; severe difficulty breathing or shortness of breath; shock; convulsions; uncontrolled or severe bleeding; sudden and/or severe pain; coughing or vomiting blood; sudden dizziness or severe weakness; profound change in vision; severe or persistent vomiting or diarrhea; and profound change in mental status.

Medically Necessary (or Medical Necessity) **–** a service or supply which is a health care service that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an Illness, Injury, disease or its symptoms, and that is

(1) Legal and is provided in accordance with generally accepted standards of medical practice,

(2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;

(3) Not Experimental or Investigational; and

(4) Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community.

Medicare – Title XVIII of the Social Security Act of 1965, as amended. Part A **–** means Medicare's hospital plan, Part B **–** means the supplementary medical plan, and Part D – means the prescription drug plan.

Mental Health Disorder – bipolar disorder, neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind.

Morbid Obesity – as determined by a Covered Person's physician, a Body Mass Index (BMI) greater than 40, or, in combination with significant medical co-morbidities, greater than 35

Nurse – a professional nurse who has the right to use the title Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) and a Registered Nurse Midwife (R.N.M.), other than a nurse who ordinarily resides in the patient's home or who is a member of the patient's immediate family

Occupational Therapist –a health care provider who is licensed to provide occupational therapy services and who provides such services in the state(s) which issued the license(s)

Partial Hospitalization –mental health or substance abuse care on an individual or group basis five (5) days a week, eight (8) hours per day in a licensed hospital, rural health center, community mental health center or substance abuse treatment facility

Physical Therapist – a health care provider who is licensed to provide physical therapy services and who provides such services in the state(s) which issued the license(s)

Physician – any licensed doctor of medicine, M.D., osteopathic Physician, D.O., dentist, D.D.S/D.M.D, podiatrist, Pod.D./D.S.C./D.P.M., doctor of chiropractic medicine, D.C., optometrist, O.D., or psychologist, Ph.D./Ed.D./Psy.D. Physician will also include a certified nurse midwife or a licensed independent social worker.

Plan Year – the twelve (12) month period ending on the date shown in the General Information section

Retiree - a former employee who was hired prior to January 1, 1993 to work at St. Luke's Hospital, who worked for St. Luke's Hospital and/or any Southcoast Health System, Inc. affiliate at least 20 years after reaching age 40, who is eligible for coverage under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), and who is enrolled in Medicare Part B

Rehabilitation Hospital – a licensed facility or Hospital which is accredited by the Joint Commission on Accreditation of Health Care Organizations and the Commission of Accreditation of Rehabilitation Facilities

Service in the Uniformed Services – the performance of duty on a voluntary or involuntary basis in a Uniformed Service under competent authority and includes active duty for training, initial active duty for training, inactive duty training, full-time National Guard duty, and a period for which a person is absent from a position of employment for the purpose of an examination to determine the fitness of the person to perform any such duty

Skilled Nursing Facility – a licensed facility which:

(1) Provides, for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse. Full-time supervision means a Physician or Registered graduate Nurse is regularly on the premises at least 40 hours per week;

(2) Maintains a daily medical record for each patient;

(3) Has a written agreement of arrangement with a Physician to provide emergency care for its patients;

(4) Qualifies as an "extended care facility" under Medicare, as amended; and

(5) Has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and convalescent nursing facility

Speech Therapist - a health care provider who is licensed to provide speech therapy services and who provides such services in the state(s) which issued the license(s)

Uniformed Service – the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in the time of war or emergency

IV. SCHEDULE OF MEDICAL BENEFITS

This Section contains a summary of the benefits made available under the Plan, as well as important information about how this Plan works.

The Plan assumes that all Covered Persons are eligible for and enrolled in Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare is the primary payor for all charges. All bills must be submitted to Medicare first. Then this Plan covers the cost of the Medicare Part A deductible and Medicare Part B deductible and coinsurance. After Medicare and the Plan have paid, most services are covered at 100% with no additional out-of-pocket costs.

IMPORTANT: The Plan is not obligated to pay claims for Covered Persons who receive care determined not to be Medically Necessary or who fail to meet eligibility criteria for coverage.

Other Questions Regarding Eligibility and Benefits

Please contact Southcoast Health Plan customer service at (877) 234-5550 if you have questions about Plan benefits or eligibility.

The Plan assumes that all Covered Persons are eligible for and enrolled in Medicare Part A (Hospital Insurance) and Part B (Medical Insurance). Medicare is the primary payor for all charges. All bills must be submitted to Medicare first. Then this Plan covers the cost of the Medicare Part A Deductible and Medicare Part B Deductible, Coinsurance, and Co-payment. After Medicare and the Plan have paid, most services are covered at 100% with no additional out-of-pocket costs.

This booklet describes coverage under this Plan. Any additional questions may be addressed to the Claim Administrator: Health Plans, Inc. at (877) 234-5550.

Preventive Care approved by Medicare including but not limited to:	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
"Welcome to Medicare" preventive visit and Yearly "Wellness" visit Wellness visit up to one (1) per person, per 12 months	100%^	Nothing^	Nothing
Routine Immunizations limited to:			
• Flu shot	100%^	Nothing^	Nothing
• Pneumococcal Pneumonia shot	100%^	Nothing^	Nothing
• Hepatitis B shot (those at medium to high risk)	100%^	Nothing^	Nothing
Routine Lab and Clinical Tests	100%^	Nothing^	Nothing

Preventive Care approved by Medicare including but not limited to:	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Colorectal Cancer Screening includes: • Routine fecal-occult blood test-up to one (1) per person age 50+, per 12 months • Routine flexible sigmoidoscopy-up to one (1) per person age 50+, per 48 months • Routine colorectal cancer screening tests or procedures (including routine colonoscopy)-up to one (1) screening per person, every 120 months or one (1) every 24 months for high-risk members	100%^ 100%^ 100%^	Nothing^ Nothing^ Nothing^	Nothing Nothing Nothing
Nutritional Counseling for those with: • kidney disease who are not on dialysis, • a kidney transplant, or • diabetes	100%^	Nothing^	Nothing
Smoking Cessation Counseling • Preventive • Non-preventive-up to eight (8) visits per person, per 12 months	100%^ 100% after Part B Deductible and Part B Coinsurance	Nothing^ Part B Coinsurance and Part B Deductible	Nothing Nothing
Cervical and Vaginal Cancer Screening/Routine Gynecological Exam (including Pap test, pelvic exam, clinical breast exam) Up to one (1) per person, per 12 months for high-risk members and one (1) every 24 months all others	100%^	Nothing^	Nothing
Breast Cancer Screening (including Routine Mammogram) Up to one (1) per person age 40+, per 12 months; one (1) baseline per person ages 35 through 39	100%^	Nothing^	Nothing
Routine Hearing Exams	Nothing	Nothing	100%

Preventive Care approved by Medicare including but not limited to:	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Routine Prostate Exams and Prostate-Specific Antigen Screening • PSA test-up to one (1) per person age 50+, per 12 months	100%^	Nothing^	Nothing
• Digital rectal exam-up to one (1) digital rectal exam per person age 50+, per 12 months	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Abdominal Aortic Aneurysm Screening (For men age 65 and over) Up to (1) per person, per lifetime	100%^	Nothing^	Nothing
Bone Mass Density Testing Up to one (1) per person, every 24 months	100%^	Nothing^	Nothing
Vision Care	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Optometrists Services (for Medicare approved outpatient services to diagnose or treat an Illness or Injury)	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Glaucoma Screening Up to one (1) per high risk person, every 12 months	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Macular Degeneration Treatment (limitations apply)	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Cataract Glasses or Contact Lenses Up to one (1) pair following cataract surgery that implants an intraocular lens	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Routine Eye Exams	Nothing	Nothing	100%
Lenses/Frames/Contact Lenses (other than post-cataract surgery)	Nothing	Nothing	100%

Doctor Services	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Allergy Testing	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Allergy Treatment	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Anesthesia (In/Outpatient)	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Chiropractor services (Excludes x-rays and massage Therapy)	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Physician Hospital Visits	100% after Part B Coinsurance and Part B Deductible	Part B Coinsurance and Part B Deductible	Nothing
Physicians Office Visits (also includes other covered professional provider services)	100% after Part B Coinsurance and Part B Deductible	Part B Coinsurance and Part B Deductible	Nothing
Podiatrist Services	100% after Part B Coinsurance and Part B Deductible	Part B Coinsurance and Part B Deductible	Nothing
Second Surgical Opinion	100% after Part B Coinsurance and Part B Deductible	Part B Coinsurance and Part B Deductible	Nothing
Surgery (Inpatient)	100% after Part B Deductible and Part B Coinsurance	Part B Coinsurance and Part B Deductible	Nothing
Surgery (Outpatient)	100% after Part B Deductible and Part B Coinsurance	Part B Coinsurance and Part B Deductible	Nothing
Surgery (Physician's office)	100% after Part B Deductible and Part B Coinsurance	Part B Coinsurance and Part B Deductible	Nothing

Inpatient Care	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Semiprivate Hospital Room & Board (including surgical services, x-rays, laboratory tests, anesthesia, drugs, medications, intensive care services)			
Days 1-60:	100% after Part A Deductible	Part A Deductible	Nothing
Days 61-90:	100% after Part A Copayment	Part A Copayment	Nothing
60 lifetime reserve days*:	100% after Part A Copayment	Part A Copayment	Nothing
Day 91-365 (per benefit period after exhausting 60 lifetime reserve days):	Nothing	100%	Nothing
Day 365+:	Nothing	Nothing	100%
Hospice Services • When covered by Medicare	100% for most services	When Medicare does not provide full benefits, the difference between the amount Medicare pays and the allowed charge	Nothing
• When not covered by Medicare	Nothing	100%	Nothing
Mastectomy and Reconstructive Surgery	100% after Part A Deductible	Part A Deductible	Nothing
Organ, Bone Marrow, and Stem Cell Transplants	Facility: covered at the inpatient/outpatient benefit level	Part B Deductible and Part B Copayment	Nothing
	Physician: 100% after Part B Coinsurance	Part B Coinsurance	Nothing
	Medicare-approved laboratory tests: 100%	Nothing	Nothing
	Living donor kidney transplant: 100%	Nothing	Nothing
Surgical Facility & Supplies	100% after Part A Deductible	Part A Deductible	Nothing
Miscellaneous Hospital Charges	100% after Part A Deductible	Part A Deductible	Nothing

*The additional days per benefit period are a combination of days in a general and/or psychiatric hospital

Inpatient Care	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Skilled Nursing Facility/Rehabilitation Hospital (member must meet Medicare requirements including having been hospitalized for at least 3 days as an inpatient)			
Facility participating with Medicare**:			
Days 1-20:	100% semiprivate benefit	Nothing	Nothing
Days 21-100:	100% semiprivate benefit after Part A Coinsurance	Part A Coinsurance	Nothing
Days 101-365:	Nothing	$10 per day	Charges in excess of $10 per day
Day 366+:	Nothing	Nothing	100%
Facility not participating with Medicare**:			
Days 1-365	Nothing	$8 per day	Charges in excess of $8 per day
Days 366+	Nothing	Nothing	100%
Outpatient Care	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Clinic Services	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Continued Active Care-Services provided within the 100 days following a hospitalization which lasted at least 3 days and must be for the purpose of treating the condition which resulted in the hospitalization. Continued Active Care covers outpatient services which include but are not limited to:			
• Drugs covered by Medicare Part B including drugs that must be administered by Medicare provider (including home infusion, injectables, chemotherapy), • Medical care service furnished by a Medicare covered provider (including clinic visits, office visits, and home visits), and • Medicare approved short-term rehabilitation therapy	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing

**Up to a combined maximum of 365 days per benefit period in a Medicare participating and/or non-participating skilled nursing facility

Outpatient Care	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Emergency Department Medical Services	100% after Part B Deductible, Part B Coinsurance and Co-payment	Part B Deductible, Part B Coinsurance and Co-payment	Nothing
Hospice Services • When covered by Medicare	100% for most services	When Medicare does not provide full benefits, the difference between the amount Medicare pays and the allowed charge	Nothing
• When not covered by Medicare	Nothing	100%	Nothing
Outpatient Department	100% after Part B Deductible, Part B Coinsurance and Co-payment	Part B Deductible, Part B Coinsurance and Co-payment	Nothing
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Preadmission Testing	100% after Part A Deductible	Part A Deductible	Nothing
Urgent Care Facility	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Mental Health & Substance Abuse	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Inpatient admission in a general or psychiatric hospital***			
• Days 1-60:	100% after Part A Deductible	Part A Deductible	Nothing
• Days 61-90:	100% after Part A Copayment	Part A Copayment	Nothing
• 60 lifetime reserve days*:	100% after Part A Copayment	Part A Copayment	Nothing
• Day 91-365 (per benefit period after exhausting 60 lifetime reserve days)***:	Nothing	100%	Nothing
• Day 366+:	Nothing	Nothing	100%

*The additional days per benefit period are a combination of days in a general and/or psychiatric hospital
*** Coverage for psychiatric hospital admissions is limited to 190 days per lifetime

Mental Health & Substance Abuse	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Outpatient visits (when visits are covered by Medicare) • Diagnostic visit • Treatment visit	100% after Part B Deductible and Part B Coinsurance 100% after Part B Deductible and 65% Coinsurance	Part B Deductible and Part B Coinsurance Part B Deductible and 35% Coinsurance	Nothing Nothing
Outpatient visits (when visits are not covered by Medicare)	Nothing	100%: - for non-biologically-based conditions up to a maximum of 24 visits per person, per Calendar Year - for biologically-based conditions up to as many visits as are medically necessary	Nothing
Other Supplies & Services	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Acupuncture	Nothing	Nothing	100%
Ambulance	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Bariatric Surgery	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Blood (For New Hampshire residents, New Hampshire Red Cross replaces blood free of charge. However, hospitals charge an administrative fee)	Nothing for first 3 units**** 100% after any Deductible for units in excess of 3	Cost of first 3 units**** (New Hampshire non-residents), any Deductible, and any Coinsurance for administrative charges	Nothing
Cardiac Rehabilitation	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing

****A hospital or skilled nursing facility may not charge a Covered Member for the first three pints of blood that the Covered Member replaces or arranges for another person or organization to replace.

Other Supplies & Services	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Chemotherapy • Inpatient	100% after Part A Deductible	Part A Deductible	Nothing
• Hospital outpatient	100% after Part B Coinsurance and Copayment	Part B Coinsurance and Copayment	Nothing
• Other outpatient setting	100% after Part B Coinsurance	Part B Coinsurance	Nothing
Cochlear Implants when meeting Medicare coverage criteria			
• Hospitalization	100% after Part A Deductible	Part A Deductible	Nothing
• Audiologist post-operative services	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
• Cochlear implant system	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Dental Services (limitations apply) See Medical Section	100% after Part A Deductible	Part A Deductible	Nothing
Diabetes Self-Management Training and Supplies	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Diabetic Testing Materials (When not covered by Medicare, including urine test strips)	Nothing	100%	Nothing
Diagnostic Imaging	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Diagnostic Laboratory	100% ^	Nothing ^	Nothing
Durable Medical Equipment • Approved home dialysis or hospice services	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
• All other durable medical equipment obtained from approved providers	100% after Part B Deductible and Part B Coinsurance	Nothing	Part B Deductible and Part B Coinsurance
Enteral and Parenteral Nutrition Therapy	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance to a maximum of $2,500 per person, per Calendar Year	All charges in excess of $2,500

Other Supplies & Services	Medicare Pays:	Retiree 2 Plan Pays:	Member Pays:
Erectile Dysfunction Treatment	Nothing	Nothing	100%
Genetic Testing and Related Services	Nothing	Nothing	100%
Hearing Aids	Nothing	Nothing	100%
Hemodialysis Services and Supplies	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Home Health Care • Visits*	Full benefit	Nothing	Nothing
• Physician's Certification for services	100% after Part B Coinsurance	Part B Coinsurance	Nothing
• Durable Medical Equipment	100% after Part B Coinsurance	Nothing	Part B Coinsurance
Injectables	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Neuromuscular Stimulators including TENS for chronic or severe pain following surgery	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Nutritionist Therapy Services	100% ^	Nothing ^	Nothing
Occupational and Physical Therapy	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Orthotics	100% after Part B Deductible and Part B Coinsurance	Nothing	Part B Deductible and Part B Coinsurance
Pain Clinics	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Prosthetics obtained from Medicare-approved supplier	100% after Part B Deductible and Part B Coinsurance	Nothing	Part B Deductible and Part B Coinsurance
Pulmonary Therapy	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Sleep Disorders	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing

*Covered by Medicare if meet medical conditions.

Other Supplies & Services	**Medicare Pays:**	**Retiree 2 Plan Pays:**	**Member Pays:**
Speech Therapy	100% after Part B Deductible and Part B Coinsurance	Part B Deductible and Part B Coinsurance	Nothing
Temporomandibular Joint Disorders (TMJ)	Nothing	Nothing	100%
Wigs	Nothing	Nothing	100%

V. MEDICAL BENEFITS

A. Covered Expenses

Under this Plan, the term "covered expense" refers to the services prescribed by a Physician and expenses incurred for medical treatment of an Illness or Injury and covered in part or in full by Medicare and/or this Plan. Covered expenses are subject to limits as shown in the Schedule of Medical Benefits for the following:

(1) Preventive Care

(a) Routine physicals

Includes one time "Welcome to Medicare" physical exam and yearly "Wellness" exam

(b) Routine immunizations

Includes flu shot, pneumococcal pneumonia shot, and Hepatitis B shot for those at medium to high risk

(c) Nutritional counseling

For Covered Persons with kidney disease who are not on dialysis, or who have had a kidney transplant or have diabetes

(d) Smoking cessation counseling

(e) Routine lab, x-rays and clinical tests

Includes certain blood tests, urinalysis, and some screening tests

(f) Routine colorectal cancer screening

Includes fecal occult blood test, sigmoidoscopy, colonoscopy, and/or barium enema

(g) Routine gynecological care

Includes vaginal cancer screening and cervical cancer screening, including Pap smear

(h) Breast cancer screening

Includes routine mammograms

(i) Bone mass density testing

For Covered Persons with certain medical conditions or meeting certain criteria as established by Medicare

(j) Abdominal aortic aneurysm screening

(k) Routine prostate exam

Includes digital rectal exam and Prostate Specific Antigen (PSA)

(2) Vision Care

(a) Medicare approved outpatient medical care services furnished by an optometrist to diagnose or treat an Illness or Injury

(b) Glaucoma screening for Covered Persons at high risk for glaucoma including diabetics, persons with a family history of glaucoma, and African-Americans age 50 and older

(c) Macular degeneration treatment for Covered Persons with age-related macular degeneration, limited to ocular photodynamic therapy with verteporfin.

(d) Cataract glasses, contact lenses, or intraocular lenses following cataract surgery with an intraocular lens. Must be provided by an ophthalmologist or an optometrist licensed to provide this service.

(3) Physician Services

(a) Allergy testing and treatment

(b) Anesthesia (In/outpatient)

(c) Chiropractic services from a licensed provider, excluding x-rays

(e) Physician hospital visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including Hospital inpatient care, Hospital outpatient visits/exams and clinic care as specified in the Schedule of Medical Benefits that is medically necessary

(f) Physician office visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including office visits

(g) Podiatrist services

Physician's services for symptomatic complaints related to the feet when corrected by a major surgical procedure or when the result of a serious medical condition, such as diabetes. Benefits may include diagnostic lab tests and x-rays, surgery that is an integral part of the treatment of foot Injury, other medically necessary foot care such as treatment for hammertoe and osteoarthritis.

Routine services, including routine care for bunions, corns, calluses, toenails, flat feet, fallen arches, partial dislocations in the feet, chronic foot strain, foot orthotics, arch supports, shoe (foot) inserts, orthopedic and corrective shoes, fittings, castings, and other services related to devices for the feet are excluded.

(h) Second surgical opinion

Second surgical opinions and in some instances a third opinion for non-emergency surgery.

(i) Surgery (inpatient/outpatient/office)

Physician or surgeon charges for a surgical operation and for the administration of anesthesia

(4) Hospital Services – Inpatient

(a) Semiprivate hospital room & board

Including semi-private room, meals, general nursing, drugs as part of inpatient treatment, surgical services, x-rays, laboratory tests, anesthesia, drugs, medications, intensive care services, hospital services and supplies, but excluding charges for a private room (unless determined to be Medically Necessary)

(b) Hospice care benefits

For Covered Persons with a life expectancy of less than six (6) months. Benefits are limited to drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment; and spiritual and grief counseling.

Medicare-approved hospice gives hospice care in a facility (e.g., a nursing home). Hospice care includes a stay in a Medicare-approved facility (room and board) when the hospice medical team determines that short-term inpatient care is necessary for pain and symptom management that cannot be addressed at home. Inpatient respite care is covered when in a Medicare-approved facility for up to five (5) days each respite period.

(c) Mastectomy

If the Covered Person has had or is going to have a mastectomy, the Covered Person may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA). For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, for:

(i) All stages of reconstruction of the breast on which the mastectomy was performed;

(ii) Surgery and reconstruction of the other breast to produce a symmetrical appearance;

(iii) Prostheses; and

(iv) Treatment of physical complications of the mastectomy, including lymphedema.

(d) Organ transplants – including bone marrow and stem cell transplants

Coverage is available to Covered Persons for organ and/or tissue transplants listed below only under certain conditions and only in a Medicare-certified facility:

Heart	Lung	Kidney
Pancreas	Intestine/multivisceral	Liver
Bone marrow	Cornea	

Covered transplant expenses: Covered Expenses which are Medically Necessary and appropriate to the transplant include:

(i) Evaluation, screening, and candidacy determination process;

(ii) Organ transplantation;

(iii) Organ procurement as follows:

Organ procurement from a non-living donor will be covered for costs involved in removing, preserving and transporting the organ;

Organ procurement from a living donor will be covered for the costs involved in screening the potential donor, as well as for medical expenses associated with removal of the donated organ and the medical services provided to the donor in the interim and for follow-up care as described below;

If the transplant procedure is a bone marrow transplant, coverage will be provided for the cost involved in the removal of the patient's bone marrow (autologous) or donated marrow (allogenic). Coverage will also be provided for search charges to identify an unrelated match, treatment and storage costs of the marrow, up to the time of reinfusion.

(iv) Follow-up care, including immuno-suppressant therapy

(e) Surgical Facility and Supplies

(f) Miscellaneous Hospital Charges

(i) Medically Necessary supplies and services including x-ray and laboratory charges.

(ii) Drugs and medicines charged by a Hospital which are obtained through written prescription by a Physician.

(iii) Administration of infusions and transfusions, including the cost of unreplaced blood and blood plasma or autologous blood and blood plasma. Expenses for storage of autologous blood or blood plasma will not be covered.

(g) Rehabilitation Hospital/Skilled Nursing Facility

Includes semi-private room, meals, skilled nursing and rehabilitative services and other supplies that are medically necessary after a 3-day minimum inpatient hospital stay for a related Illness or Injury

(5) Hospital Services – Outpatient

(a) Clinic services

(b) Continued active care

Outpatient services which include but are not limited to drugs covered by Medicare Part B, including drugs that must be administered by a Medicare provider (including home infusion, injectables, chemotherapy); medical care service furnished by a Medicare covered provider (including clinic visits, office visits, and home visits); and Medicare approved short-term rehabilitation therapy.

(c) Emergency medical services

Includes accident treatment and emergency medical care for an Injury, a sudden Illness, or an Illness that quickly increases in severity

(d) Hospice care benefits

For Covered Persons with a life expectancy of less than six (6) months. Benefits are limited to drugs for pain relief and symptom management; medical, nursing, and social services; certain durable medical equipment; and spiritual and grief counseling.

Medicare-approved hospice gives hospice care in the Covered Person's home. Hospice care doesn't include a stay in a facility (room and board) unless the hospice medical team determines that short-term inpatient care is necessary for pain and symptom management that cannot be addressed at home.

(e) Outpatient department

(f) Outpatient surgery in Hospital, ambulatory center or other properly licensed facility

For approved procedures in a facility where the patient is released within 24 hours

(g) Preadmission testing

Preadmission tests on an outpatient basis for a scheduled Hospital admission or surgery

(h) Urgent care facility/walk-in clinic

Emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a Hospital) to treat a sudden Illness or Injury that is not a medical emergency

(6) Mental Health/Substance Use Disorders

Inpatient confinement (including confinement in a residential treatment facility) or Partial Hospitalization/Intensive Outpatient Treatment for the treatment of a mental Illness in a licensed general Hospital, in a mental Hospital under the direction and supervision of the Department of Mental Health, or in a private mental Hospital licensed by the Department of Mental Health, or confinement or Partial Hospitalization/Intensive Outpatient Treatment in a public or private substance use disorder facility.

Outpatient treatment of mental health disorders and outpatient treatment of substance use disorders on an outpatient basis provided services are furnished by a:

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

(c) Community mental health center, or other mental health clinic or day care center which furnishes mental health services, subject to the approval of the Department of Mental Health;

(d) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist; or

(g) Psychiatrist.

(7) Other Services and Supplies

(a) Ambulance services

(i) To the nearest Hospital or medical facility which is equipped to provide the service required;

(ii) When Medically Necessary, from a Hospital; or

(iii) For an air ambulance or rail transportation to the nearest medical facility equipped to provide care when failure to do so may seriously jeopardize the health or risk the life of the patient

(b) Bariatric surgery for the treatment of Morbid Obesity

(c) Blood

Coverage for blood is based on whether it is provided on an inpatient or outpatient basis, as described in the Schedule of Benefits

(d) Cardiac rehabilitation

Expenses for Cardiac Rehabilitation Program (limited to Phase I and Phase II only) provided such treatment is recommended by the attending Physician. Phase I consists of acute inpatient hospitalization, whether for heart attack or heart surgery, highly supervised with a tailored exercise program with continuous monitoring during exercise. Phase II consists of supervised outpatient treatment for Covered Persons who have left the Hospital but still need a certain degree of supervised physical therapy and monitoring during exercise. Phase II services are usually tailored to meet the Covered Person's individual need. Benefits are not payable for Phase III which consists of outpatient services without supervision. The Phase III program is developed for patients who are well enough to continue exercising on their own, monitoring their own progress.

(e) Chemotherapy and radiation therapy

(f) Cochlear implants

When meeting Medicare coverage criteria, includes hospitalization, audiologist post-operative services, and cochlear implant system

(g) Dental services

Includes reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; services by a dentist, surgical day care unit, or ambulatory surgical facility when Medicare determines that a medical condition (ex. hemophilia, heart disease) or the severity of a dental procedure necessitates surgery to be safely performed in a surgical day care unit or ambulatory surgical facility; services when an integral part of either a covered procedure; and extractions in preparation for radiation treatment for neoplastic diseases involving the jaw

(h) Diabetes self-management training, education, and testing materials

Includes blood glucose testing monitors, blood glucose test strips, urine test strips, lancet devices and lancets, blood glucose control solutions, diabetes self-management, diabetes testing materials, and therapeutic shoes (in some cases)

(i) Diagnostic imaging (MRI, CT scan, EKGs, and other diagnostic tests)

(j) Diagnostic x-ray and laboratory

Outpatient diagnostic laboratory tests, diagnostic x-ray, and other diagnostic tests

(k) Durable medical equipment

Rental or purchase of durable medical equipment to aid impaired functions, including but not limited to: wheelchairs, walkers, standard hospital-type bed, and other durable medical or surgical equipment

(l) Enteral formulas and modified low protein food products

Enteral formulas (to treat malabsorption caused by Crohn's disease, chronic intestinal pseudo-obstruction; gastroesophageal reflux; gastrointestinal motility; ulcerative colitis; inherited diseases of amino acids and organic acids); and food products modified to be low protein (to treat inherited diseases of amino acids and organic acids)

(m) Genetic counseling

(n) Hemodialysis (renal therapy) services at a Medicare-approved dialysis center

(o) Home health care

Home Health Care Agency care in accordance with a home health care plan. Home health care means a visit by a member of a home health care team. Each such visit that lasts for a period of four (4) hours or less is treated as one (1) visit. Covered Services include:

(i) Part-time or intermittent nursing care rendered by a Registered Nurse (R.N.);

(ii) Services provided by a Licensed Practical Nurse (L.P.N.), a vocational nurse, or public health nurse who is under the direct supervision of a Registered Nurse;

(iii) Services provided by home health aides; and

(iv) Medical supplies, drugs, and medications prescribed by a Physician and laboratory services by or on behalf of a Hospital to the extent such items would have been considered by this Plan had the Covered Person remained in the Hospital.

No benefits will be provided for services and supplies not included in the home health care plan, transportation services, Custodial Care and housekeeping, or for services of a person who ordinarily resides in the home of the Covered Person, or is a close relative of the Covered Person.

(p) Injectable medications which must be administered by a Medicare covered provider

(q) Neuromuscular stimulators including TENS for chronic or severe pain following surgery

(r) Nutritionist (licensed dietician)

Medicare approved outpatient services to treat diabetes or kidney disease or those with a kidney transplant in the prior 36 months

(s) Occupational and physical therapy

Medicare approved outpatient short-term rehabilitative occupational therapy (evaluation and treatment after an Illness or Accident which impairs the ability to perform activities of daily living)

Medicare approved physical therapy evaluation and treatment for Injuries or disease which impairs the ability to function

(t) Orthotic/Prosthetic Items

Including arm, leg, back, and neck braces; artificial eyes; artificial limbs (and their replacement parts); and prosthetic devices needed to replace an internal body part or function (including ostomy supplies, and parenteral and enteral nutrition therapy) when medically necessary

(u) Oxygen

Rental of oxygen equipment, systems for furnishing oxygen, oxygen storage containers, tubing and related supplies for the delivery of oxygen, and oxygen contents for Covered Persons with a severe lung disease, arterial blood gas level falling within a certain range, or when alternative measures have been unsuccessful

Portable oxygen is not covered when oxygen is only needed during sleep or when provided only as a backup to a stationary oxygen system

(v) Pain clinics

(w) Pulmonary therapy

Comprehensive pulmonary rehabilitation program for moderate to very severe chronic obstructive pulmonary disease (COPD)

(x) Sleep disorders

Sleep disorder testing, treatment, and related supplies, including diagnosis and treatment for Obstructive Sleep Apnea

(y) Speech Therapy

Evaluation and treatment to regain and strengthen speech and language skills including cognitive and swallowing skills

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

Total benefits payable under this Plan will not exceed approved Medicare charges. These are charges generally made for similar services and those prevailing in the locality for similar services as determined by Medicare regulations. Benefits of this Plan do not duplicate those provided by Medicare, but supplement Medicare coverage as described in the Schedule of Benefits. The following are excluded from Covered Expenses and no benefits shall be paid:

(1) Any services not covered or approved by Medicare, except for benefits specifically stated as covered

(2) Expenses incurred prior to the effective date of coverage or after coverage is terminated

(3) Services or supply which are not considered Medically Necessary as defined in the Article titled "Definitions", whether or not prescribed and recommended by a Physician or covered provider, except for benefits specifically stated as covered under the Plan

(4) Experimental or Investigational drugs, devices, medical treatments or procedures as defined in the Article titled "Definitions"

(5) Services, supplies, or treatment not recognized as generally accepted standards of medical practice for the diagnosis and/or treatment of an active Illness or Injury

(6) Expenses incurred outside the United States if the Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies

(7) Expenses for which there is no legal obligation to pay, such as that portion of any charge which would not have been made if the patient did not have this coverage, or any charge for services or supplies which are normally furnished without charge

(8) Expenses incurred in connection with an Injury arising out of, or in the course of, any employment for wage or profit, or disease covered with respect to such employment, by any Worker's Compensation Law, Occupational Disease Law or similar legislation, with the exception of when a Covered Person is not covered by Worker's Compensation Law and lawfully chose not to be

(9) Expenses incurred in connection with an Injury arising out of, or in the course of, the commission of a crime by the Covered Person or while engaged in an illegal act, illegal occupation or felonious act, or aggravated assault for which the Covered Person is convicted of a felony charge. This exclusion does not apply to (a) Injuries sustained by a Covered Person who is a victim of domestic violence or (b) Injuries resulting from a medical condition (including both physical and mental health conditions)

(10) Medical expenses incurred on account of Injury or Illness resulting from war or any act of war, whether declared or undeclared, or expenses resulting from active duty in the Uniformed Services of any international armed conflict or conflict involving armed forces of any international authority

(11) Physician's fees for any treatment which is not rendered by or in the physical presence of a Physician, except as specifically stated as covered under this Plan

(12) Communication, transportation, time spent traveling, or for expenses connected to traveling that may be incurred by a Physician, Covered Person, or covered provider, in the course of rendering services, except for benefits specifically stated as covered under the Plan

(13) Court-ordered treatment or any treatment not initiated by a Physician or covered Provider of any kind

(14) Treatment, services or supplies provided by a member of the Covered Person's immediate family, a person who ordinarily resides with the Covered Person, or the Covered Person. The term immediate family includes, but is not limited to, the Covered Person's spouse, child, brother, sister, or parent

(15) Acupuncture therapy

(16) Chelation therapy

(17) Cosmetic or reconstructive surgery, except for benefits specifically stated as covered under the Plan

(18) Custodial Care designed essentially to assist the Covered Person, whether disabled or not, in meeting the activities of daily living, including services which constitute personal care such as help in walking and getting in or out of bed, assistance in bathing, dressing, feeding, using the toilet, preparation of special diets and supervision over medication which can normally be self-administered. Such services and supplies are deemed to be Custodial Care whenever and wherever furnished, without respect to the practitioner or provider by whom or by which they are prescribed, recommended or performed, except for the Custodial Care described under benefits titled "Hospice Care."

(19) Dentures, dentistry, oral surgery, treatment of teeth and gum tissues or dental X-rays, except for benefits specifically stated as covered under this Plan

(20) Erectile dysfunction treatment

(21) Gender dysphoria treatment, including but not limited to, counseling, gender reassignment surgery or hormone therapy and related preoperative and postoperative procedures, which, as their objective, change the person's sex and any related complications

(22) Genetic testing or related services, except for benefits specifically stated as covered

(23) Health, swim club and tanning club memberships for any reason

(24) Hearing aids or such similar devices, or the fitting of hearing aids, except for benefits specifically stated as covered under this Plan

(25) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, massage therapy,

aromatherapy and alternative medicine, except for benefits specifically stated as covered under this Plan

(26) Immunizations, except for benefits specifically stated as covered under this Plan

(27) Inpatient care in excess of 365 days per benefit period

(28) Lenses, frames, and contact lenses, except for benefits specifically stated as covered under this Plan

(29) Long term care

(30) Marital counseling

(31) Medical supplies that are incidental to the treatment received in a physician or other provider's office or are provided as take-home supplies

(32) Methadone maintenance and treatment

(33) Orthoptics and visual therapy for the correction of vision

(34) "Over-the-counter" drugs or medical supplies which can be purchased without a prescription or when no Injury or Illness is involved, except for benefits specifically stated as covered under this Plan

(35) Pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies

(36) Personal comfort, hygiene or convenience items such as televisions, telephones, radios, air conditioners, humidifiers, dehumidifiers, physical fitness equipment, whirlpool baths, education, or educational aids or training whether or not recommended by a Physician

(37) Podiatry services for the routine care, including care for bunions, corns, calluses, toenails, flat feet, fallen arches, and chronic foot strain

(38) Private duty nursing

(39) Prescription drugs

(40) Routine hearing exams

(41) Sex therapy

(42) Treatment of Temporomandibular Joint Disorders (TMJ)

(43) Vision exams, except for benefits specifically stated as covered

(44) Visual refraction surgery, including radial keratotomy

(45) Wigs

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility

Retirees who are former employees, who were hired prior to January 1, 1993 to work at St. Luke's Hospital, who worked for St. Luke's Hospital and/or any Southcoast Health System, Inc. affiliate for at least 20 years after reaching age 40, and who are eligible to enroll in Medicare, are eligible to participate in this Plan.

B. Enrollment and Participation

Enrollment occurs and participation begins upon the later of becoming Medicare eligible or retirement for a Retiree who, immediately prior to retirement or becoming Medicare eligible, is covered under the Southcoast Hospitals Group, Inc. Employee Group Health Care Plan and otherwise meets the eligibility criteria above. See Human Resources to initiate enrollment.

VIII. COORDINATION OF BENEFITS

This Medicare Supplement Plan provides benefits to Retirees and requires that Covered Persons be entitled to (i.e., enrolled in) Medicare Parts A and B.

A. Persons Covered by Medicare

In general, Medicare is the primary payer of benefits for Covered Persons and this Plan is secondary, except as described below. Covered Persons who are eligible for Medicare, but who have not applied for entitlement to Medicare Part A or Part B, or who have applied for entitlement to Part A and/or Part B, but have chosen not to elect Part B, will have their benefits determined under this Plan on an assumptive basis, whereby benefits will be calculated as if Medicare provided reimbursement for the expenses being claimed.

This Plan will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payer (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. The Medicare secondary payer rules under Social Security Act §1862(b) (42 U.S.C. Section 1395y(b)(5)), as may be amended from time to time, and applicable Federal regulations are hereby incorporated by reference and shall supersede any inconsistent provision(s) of this Plan. In addition, this Plan will coordinate benefits with other plans as described below.

B. Maximum Benefits under All Plans

If any Covered Person covered under this Plan also is covered under one or more Other Plans and the sum of the benefits payable under all the Plans exceeds the Covered Person's eligible charges during any claim determination period, then the benefits payable under all the Plans involved will not exceed the eligible charges for such period as determined under this Plan. Benefits payable under another Plan are included, whether or not a claim has been made. For these purposes:

(1) "Claim Determination Period" means a Calendar Year, and

(2) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include charges specifically excluded from benefits under this Plan that also may be eligible under any Other Plans covering the Covered Person for whom the claim is made.

C. Other Plan

"Other Plan" means the following plans providing benefits or services for medical and dental care or treatment:

(1) Group insurance or any other arrangement for coverage for employees in a group, whether on an insured or uninsured basis.

(2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid.

(3) Vehicle insurance. When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each Covered Person will be deemed to have full no-fault coverage to the maximum available in that state, whether or not the Covered Person is in compliance with the law, or whether or not the maximum coverage is carried.

D. Determining Order of Payment

If a Covered Person is covered under two or more health Plans in addition to Medicare Parts A and B, benefits will be paid under this Plan as follows:

(1) If the Covered Person is covered under another group health plan on the basis of the Covered Person's or the subscriber's employment status, the other group health plan will pay first, Medicare will pay second and this Plan will pay third.

(2) If the Covered Person is covered under another Medicare supplement plan, Medicare pays first and the Plan covering the Person other than as an Eligible Dependent, for example as a member, subscriber, policyholder or retiree, pays second. If the Covered Person is covered under another Medicare supplement plan, Medicare pays first and the Plan covering the Person as an Eligible Dependent pays second, and this Plan pays third.

(3) If no Plan is determined to have primary benefit payment responsibility, then the Plan that has covered the Covered Person for the longest period has the primary responsibility.

(4) A Plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.

E. Facilitation of Coordination

For the purpose of Coordination of Benefits, the Claim Administrator:

(1) May release to, or obtain from, any other insurance company or other organization or individual any claim information and any individual claiming benefits under the Plan must furnish any information that the Plan sponsor may require.

(2) May recover on behalf of the Plan any benefit overpayment from any other individual, insurance company, or organization.

(3) Has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the Plan have been made by such organization.

F. Enrollment and Provision of Benefits without Regard to Medicaid Eligibility

In enrolling a Retiree as a Covered Person or in determining or making any payments for benefits of a Retiree as a Covered Person, the fact that the Covered Person is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.

G. Medicare and Medicaid Reimbursements

The Plan will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any Covered Person that should have been borne by this Plan. Similarly, the Plan will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.

H. Right to Receive and Release Necessary Information

For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the Employer, through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes. Any person claiming benefits under this Plan will furnish such information as may be necessary to implement this provision.

I. Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision, have been made under any other plans, the Employer will have the sole right and discretion to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan.

J. Right of Recovery

Whenever payments have been made by the Employer with respect to allowable expenses in a total amount which is, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Employer will have the right to recover such payments to the extent of such excess from any persons to or for or with respect to whom such payments were made and any other insurance companies and any other organizations.

IX. PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator will be appointed by the Employer.

B. Allocation of Authority

Except as to those functions reserved by the Plan to the Employer or the Board of Directors of the Employer, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator shall (except as to matters reserved to the Board of Directors by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:

(1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator or the Board of Directors with respect to any matter relating to the administration of the Plan will be conclusive and binding on all persons.

C. Powers and Duties of Plan Administrator

The Plan Administrator will have the following powers and duties:

(1) To require any person to furnish such reasonable information as the Plan Administrator may request for the proper administration of the Plan as a condition to receiving any benefits under the Plan.

(2) To make and enforce such rules and regulations and prescribe the use of such forms as the Plan Administrator will deem necessary for the efficient administration of the Plan.

(3) To decide on questions concerning the Plan and the eligibility of any Retiree to participate in the Plan, in accordance with the provisions of the Plan.

(4) To determine the amount of benefits that will be payable to any person in accordance with the provisions of the Plan; to inform the Employer, as appropriate, of the amount of such Benefits; and to provide a full and fair review to any covered individual whose claim for benefits has been denied in whole or in part.

(5) To designate other persons to carry out any duty or power that would otherwise be a fiduciary or clerical responsibility of the Plan Administrator under the terms of the Plan; and to retain such actuaries, accountants (including employees who are actuaries or accountants), consultants, third-party administration service providers, legal counsel, or other specialists, as the Plan Administrator may deem appropriate and necessary for the Plan's effective administration.

D. Delegation by the Plan Administrator

The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the committee, or to eliminate the committee entirely.

The Plan Administrator also will have the power and duty to retain the services of one or more health care professionals, for the purpose of reviewing benefit claims that are under appeal for reasons based on medical judgment, such as medical necessity or experimental treatments.

The Plan Administrator, the Employer (and any person to whom any duty or power in connection with the operation of the Plan is delegated), may rely upon all tables, valuations, certificates, reports, and opinions furnished by any duly appointed actuary, accountant (including employees who are actuaries or accountants), consultant, third-party administration service provider, legal counsel, or other specialist, and the Plan Administrator, Employer, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

E. Indemnification and Exculpation

The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and employees of the Employer will be indemnified and held harmless by the Employer against and from any and all loss, cost, liability, or expense that may be imposed upon or reasonably incurred by them in connection with or resulting from any claim, action, suit, or proceeding to which they may be a party or in which they may be involved by reason of any action taken or failure to act under this Plan and against and from any and all amounts paid by them in settlement (with the Employer's written approval) or paid by them in satisfaction of a judgment in any such action, suit, or proceeding. Indemnification under this Section will not be applicable to any person if the loss, cost, liability, or expense is due to the person's failure to act in good faith or misconduct.

F. Compensation of Plan Administrator

Unless otherwise agreed to by the Board of Directors, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses incurred in the performance of the Plan Administrator's duties will be paid by the Employer.

G. Bonding

Unless required by ERISA, by the Board of Directors, or by any other federal or state law, neither the Plan Administrator nor any of the Plan Administrator's delegates will be required to give any bond or other security in any jurisdiction in connection with the administration of this Plan.

H. Payment of Administrative Expenses

All reasonable expenses incurred in administering the Plan, including but not limited to administrative fees and expenses owing to any third-party administrative service provider, actuary, consultant, accountant, specialist, or other person or organization that may be employed by the Plan Administrator in connection with the administration thereof, will be paid by the Employer unless the Employer directs the Plan to pay such expenses and such payment by the Plan is permitted by law.

X. TERMINATION OF COVERAGE

A. Termination Events

The participation in and coverage under this Plan of any Retiree terminates on the earliest of:

(1) On the day in which the Retiree ceases to be in a class of eligible Retirees.

(2) On the day in which the Employer terminates the Retiree's coverage.

(3) On the day this Plan terminates.

(4) On the day in which the Retiree dies.

(5) On the first day of the period for which the Retiree fails to make any required contributions, if applicable.

(6) If a Retiree is an in-patient at a hospital at the time that coverage would normally terminate due to a reason stated above, coverage will continue through the hospital admission but will terminate upon discharged from the hospital.

B. Rescissions

In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to your coverage under the Plan, or b) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, you may be responsible for any benefit payments made during the relevant period. For any rescission (retroactive termination of coverage that is related to fraud or intentional misrepresentation), the Plan Administrator will provide thirty (30) days advance written notice and you will have the right to appeal the Plan's termination of coverage.

XI. HIPAA PRIVACY AND SECURITY PROVISIONS

There are three circumstances under which the Plan may disclose an individual's protected health information to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether an individual is enrolled in the Plan.

Second, the Plan may disclose summary health information to the Plan Sponsor. The Plan Sponsor must limit its use of that information to obtaining quotes from insurers or modifying, amending, or terminating the Plan. Summary health information is information that summarizes claims history, claims expenses, or types of claims without identifying the individual.

Third, the Plan may disclose an individual's protected health information to the Plan Sponsor for Plan administrative purposes. This is because employees of the Plan Sponsor perform many of the administrative functions necessary for the management and operation of the Plan. The Plan Sponsor has certified to the Plan that the Plan's terms have been amended to incorporate the terms of this summary. The Plan Sponsor has agreed to abide by the terms of this summary. The Plan's privacy notice also permits the Plan to disclose an individual's protected health information to the Plan Sponsor as described in this summary.

Here are the restrictions that apply to the Plan Sponsor's use and disclosure of an individual's protected health information:

- The Plan Sponsor will only use or disclose an individual's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.

- If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information as required by the HIPAA regulations.

- The Plan Sponsor will not use or disclose an individual's protected health information for employment related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.

- The Plan Sponsor will promptly report to the Plan any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.

- The Plan Sponsor will allow an individual or the Plan to inspect and copy any protected health information about the individual that is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the Plan must follow in this regard. There are some exceptions.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.

- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2004). An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.

- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of an individual's protected health information available to the Plan and to the U.S. Department of Health and Human Services.

- The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business employee when the Plan Sponsor no longer needs an individual's protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

In addition to the Privacy Officer, the following classes of employees or other workforce members under the control of the Plan Sponsor may be given access to an individual's protected health information for the purposes set forth above:

- Executive Director of Compensation and Benefits
- Director of Compensation and Benefits
- Medical Director
- Director, Ambulatory Pharmacy Services
- Senior Vice President of Human Resources
- Vice President of Human Resources
- Human Resources Director
- Wellness Coordinator
- Benefits Manager
- Senior Benefits Analyst
- Benefits Specialist
- Human Resources Business Partner
- Manager, Employee Assistance Program

Employees and other workforce members at the direction of the above listed classes of employees

- Benefits Administrator
- Human Resources Director Secretary
- Human Resources Consultant
- Human Resources Receptionist
- Human Resources Recruiter
- Human Resources Operations Coordinator
- Accounting Team Leader
- Administrative Assistant to Medical Director
- Administrative Assistant to Plan Administrator
- Administrative Assistant to Sr. Vice President Human Resources

This list includes every class of employees or other workforce members under the control of the Plan Sponsor who may receive an individual's protected health information. If any of these employees or workforce members use or disclose an individual's protected health information in violation of the rules that are set out in this summary, the employees or workforce members will be subject to disciplinary action and sanctions. If the Plan Sponsor becomes aware of any such violations, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to correct the violation, to impose appropriate sanctions, and to mitigate any harmful effects to an individual.

Security Provisions

The Plan Sponsor will receive electronic protected health information. The information may be identified to the individual in some cases. In relation to such electronic protected health information, the Plan Sponsor certifies to the Plan that it agrees to:

- Take appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;
- Require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;
- Report to the Plan any security incident that the Plan Sponsor becomes aware of; and
- Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Covered Person, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, where any party besides the Plan may be responsible for expenses arising from an incident, and/or funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions , third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").

(2) Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person(s) shall be a trustee over those Plan assets.

(3) In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

(4) If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

B. Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to pursue said rights and/or obligations.

(2) If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Injury, Illness, disease or disability to the extent of such conditional payment by the Plan plus reasonable costs of collection. The Covered Person(s) is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(3) The Plan may, at its own discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.

(4) If the Covered Person(s) fails to file a claim or pursue damages against:

(a) The responsible party, its insurer, or any other source on behalf of that party;

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(c) Any policy of insurance from any insurance company or guarantor of a third party;

(d) Worker's compensation or other liability insurance company; or,

(e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The

Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person(s) are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's(s') obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.

(3) The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person (s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

(4) These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person (s).

(5) This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness Injury, disease or disability.

D. Covered Person is a Trustee Over Plan Assets

(1) Any Covered Person(s) who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury, Illness, disease or disability. By virtue of this status, the Covered Person(s) understands that he/she is required to:

(a) Notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;

(b) Instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

(c) In circumstances where the Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person(s) obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,

(d) Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.

(2) To the extent the Covered Person(s) disputes this obligation to the Plan under this section, the Covered Person(s) or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.

(3) No Covered Person(s), beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

E. Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any Coverage (including but not limited to Coverage resulting from a judgment at law or settlements), the benefits under this Plan shall apply only as an excess over such other sources of Coverage, except as provided for under the Plan's Coordination of Benefits section. The Plan's benefits shall be excess to:

(1) The responsible party, its insurer, or any other source on behalf of that party;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;

(3) Any policy of insurance from any insurance company or guarantor of a third party;

(4) Worker's compensation or other liability insurance company; or

(5) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

F. Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person (s), and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person (s), such that the death of the Covered Person, or filing of bankruptcy by the Covered Person (s), will not affect the Plan's equitable lien, the funds over which the Plan has a lien, or the Plan's right to subrogation and reimbursement.

G. Wrongful Death

In the event that the Covered Person (s) dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply, and the entity pursuing said claim shall honor and enforce these Plan rights and terms by which benefits are paid on behalf of the Covered Person(s) and all others that benefit from such payment.

H. Obligations

(1) It is the Covered Person(s)' obligation at all times, both prior to and after payment of medical benefits by the Plan:

(a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;

(b) To provide the Plan with pertinent information regarding the illness, disease, disability, or Injury, including accident reports, settlement information and any other requested additional information;

(c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;

(d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement;

(e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received;

(f) To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement;

(f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage;

(h) To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft;

(i) In circumstances where the Covered Person(s) is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person(s) obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft; and

(j) To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person(s) over settlement funds is resolved.

(2) If the Covered Person (s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said Injury, Illness, disease or disability, out of any proceeds, judgment or settlement received, the Covered Person (s) will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person (s).

(3) The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person (s)' cooperation or adherence to these terms.

I. Offset

If timely repayment is not made, or the Covered Person(s) and/or his/her attorney fails to comply with any of the requirements of the Plan, the Plan has the right, in addition to any other lawful means of recovery, to deduct the value of the Covered Person(s)' amount owed to the Plan. To do this, the Plan may refuse payment of any future medical benefits and any funds or payments due under this Plan on behalf of the Covered Person(s) in an amount equivalent to any outstanding amounts owed by the Covered Person(s) to the Plan. This provision applies even if the Covered Person(s) has disbursed settlement funds.

J. Minor Status

(1) In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the

minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

(2) If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

K. Language Interpretation

The Plan Administrator retains sole, full and final discretionary authority to construe and interpret the language of this provision, to determine all questions of fact and law arising under this provision, and to administer the Plan's subrogation and reimbursement rights. The Plan Administrator may amend the Plan at any time without notice.

L. Severability

In the event that any section of this provision is considered invalid or illegal for any reason, said invalidity or illegality shall not affect the remaining sections of this provision and Plan. The section shall be fully severable. The Plan shall be construed and enforced as if such invalid or illegal sections had never been inserted in the Plan.

XIII. AMENDMENT AND TERMINATION OF PLAN

A. Amendment

The Employer has the right to amend this Plan in any and all respects at any time, and from time to time, without prior notice.

Any such amendment will be by a written instrument signed by a duly authorized Officer of the Employer.

The Plan Administrator will notify all Covered Persons of any amendment modifying the material terms of the Plan as soon as is administratively feasible after its adoption, but in no event later than 210 days after the close of the Plan Year in which the amendment has been adopted. Such notification will be in the form of a Summary of Material Modifications (within the meaning of ERISA §102(a)(1) and Labor Reg. §2520.104b-3) unless incorporated in an updated Summary Plan Description (as described in ERISA § 102(b)).

Notwithstanding the above, to the extent the material change is a material reduction in covered services or benefits (as defined in Labor Reg. §2520.104b-3(d)(3)), such Summary of Material Modifications shall be distributed within 60 days of the date of adoption of such change.

B. Termination of Plan

Regardless of any other provision of this Plan, the Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.

C. Termination by Dissolution, Insolvency, Bankruptcy, Merger, etc.

This Plan will automatically terminate if the Employer (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

XIV. GENERAL PROVISIONS

A. Company Funding

All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Retirees shall have any right, title, or interest whatever in or to any investment reserves, accounts, or funds that the Employer may purchase, establish, or accumulate to aid in providing benefits under this Plan. Nothing contained in this Plan, and no action taken under its provisions, shall create a trust or fiduciary relationship of any kind between the Employer and a Retiree or any other person. Neither a Retiree nor a beneficiary of a Retiree shall acquire any interest greater than that of an unsecured creditor.

B. In General

Any and all rights provided to any person under this Plan shall be subject to the terms and conditions of the Plan. This Plan shall not constitute a contract between the Employer and any Covered Person. Likewise, maintenance of this Plan shall not be construed to give the right to any benefits not specifically provided by the Plan.

C. Waiver and Estoppel

No term, condition, or provision of this Plan shall be deemed to be waived, and there shall be no estoppel against enforcing any provision of the Plan, except through a writing of the party to be charged by the waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless explicitly made so, and it shall operate only with regard to the specific term or condition waived, and shall not be deemed to waive such term or condition in the future, or as to any act other than as specifically waived. No Retiree or eligible Beneficiary other than as named or described by class in the waiver shall be entitled to rely on the waiver for any purpose.

D. Effect on Other Benefit Plans

Amounts credited or paid under this Plan shall not be considered to be compensation for the purposes of a qualified pension plan maintained by the Employer. The treatment of the amounts paid under this Plan under other employee benefit plans shall be determined under the provisions of the applicable employee benefit plan.

E. Nonvested Benefits

Nothing in this Plan shall be construed as creating any vested rights to benefits in favor of any Retiree.

F. Interests not Transferable

The interests of the Retiree under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, assigned or encumbered without the written consent of the Plan Administrator.

G. Severability

If any provision of the Plan shall be held invalid or illegal for any reason, any invalidity or illegality shall not affect the remaining parts of the Plan, but the Plan shall be construed and enforced as if the invalid or illegal provision had never been inserted. The Employer shall have the privilege and opportunity to correct and remedy those questions of invalidity or illegality by amendment as provided in the Plan.

H. Headings

All Article and Section headings in this Plan have been inserted for convenience only and shall not determine the meaning of the content thereof.

I. Applicable Law

This Plan shall be governed and construed in accordance with the Employee Retirement Income Security Act of 1974 (ERISA), as amended. Consistent with the terms of ERISA, federal law will preempt state law where applicable.

J. Limitations on Actions

Any legal action against the Plan must be brought within three (3) years of the initial denial of any benefit, except as specifically provided otherwise under ERISA.

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

This section describes a Covered Person's rights and obligations with respect to filing claims, receiving timely notice about whether and the extent to which benefits are payable, and the option to appeal a claim that has been denied in whole or in part.

Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to Conifer and the Claim Administrator. As directed by the Plan Administrator, Conifer makes initial claim and initial appeal determinations of Medical Necessity and the Claim Administrator makes initial claim and initial appeal determinations on all other matters based on the specific terms of the Plan. The Plan Administrator has authority to determine the amount of benefits that will be paid on any particular benefit claim, and has discretion and authority to make factual findings regarding a claim and to interpret the terms of the Plan as they apply to the claims.

The steps involved in claims and appeals processing are outlined below. Important details about the required procedures and Covered Persons' rights are included in Sections A-F below.

(1) All initial claims must be filed within one (1) year of the Expense Incurred Date (defined in the Article titled "Definitions" of this Summary Plan Description).

(2) As directed by the Plan Administrator, initial determinations about benefits payable based on the specific term of the Plan are made by Conifer for claims that require precertification of Medical Necessity and by the Claim Administrator for all other claims. The Covered Person will be notified of the initial determination within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

(3) If the claim is denied in whole or in part, and the Covered Person disputes the determination, he or she may confirm that the claim was properly processed by contacting Conifer regarding claims denied based on a lack of Medical Necessity or the Claim Administrator regarding all other claim denials. The Covered Person may also immediately file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims,* below). In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may also request a simultaneous external review.

(4) As directed by the Plan Administrator, any internal appeal filed will be reviewed by Conifer regarding claims denied due to a lack of Medical Necessity, or the Claim Administrator regarding all other claim denials. The appeal determination will be based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below). In cases of Urgent Care

Claim denials based on medical judgment for which an expedited external review has been requested, the Independent Review Organization (IRO) will issue a determination.

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal with the Claim Administrator, within the time periods specified in Chart B, below. The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final appeal available under the Plan.

(6) If the final internal appeal is denied in whole or in part and the denial is related to a rescission or is based on medical judgment, and the Covered Person disputes the determination, the Covered Person (or authorized representative) has the right to request an external review by an independent review organization (IRO) within the time periods specified in Chart B, below. The IRO will review the denial and issue a final decision within the period specified for the type of claim that is the subject of the review (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below).

A. Who May File a Claim

A claim may be filed by a Covered Person, his or her authorized representative, or his or her health care service provider. To designate an "authorized representative," a Covered Person must submit a request in writing to the Claim Administrator. After an authorized representative has been designated, all subsequent notices and decisions concerning claims will be provided to the Covered Person through his or her authorized representative. The forms required to authorize a representative are available from the Claim Administrator.

For the purposes of this Article, "claimant" refers to the Covered Person to whom the claim relates or, as applicable, to the Covered Person's authorized representative.

B. Types of Claims

The time limits applicable to claims and appeals depend on the type of claim at issue. The categories of potential claims are defined below.

(1) Urgent Care Claim–A claim for medical care or treatment where using the time periods for making non-urgent care determinations (a) could seriously jeopardize the life or health of the Covered Person or the ability of the Covered Person to regain maximum function, or (b) in the opinion of a Physician with knowledge of the Covered Person's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment being claimed.

(2) Concurrent Care Claim–A claim for an extension of the duration or number of treatments provided through a previously-approved benefit claim.

(3) Pre-Service Care Claim–A claim for a benefit that requires approval (usually referred to as precertification or preauthorization) under the Plan in advance of obtaining medical care.

(4) Post-Service Care Claim–A claim for services that have already been provided or that do not fall into any of the categories above.

C. When and How to File a Claim

A Covered Person must submit, or ensure that his or her provider submits, an initial claim for benefits within one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

How a claim may be filed depends on the type of claim:

(1) Urgent Care Claims

(a) Urgent Care Claims for services or supplies required to be precertified as Medically Necessary may be submitted verbally by calling Conifer at (877) 234-5550 or by any method available for Non-Urgent Care Claims and Post-Service Care Claims.

(b) Urgent Care Claims for services or supplies that do not require precertification may be submitted verbally by calling the Claim Administrator at (877) 234-5550 or by any method available for Non-Urgent and Post-Service Claims.

(2) Non-Urgent Care Claims and Post-Service Claims:

(a) Non-Urgent Care Claims and Post-Service Claims for services or supplies required to be precertified as Medically Necessary may be filed electronically or in writing and must be submitted to Conifer using one of the following methods:

- Electronically
- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 792-1188

Physical and Mailing Address:
Conifer Value-Based Care, LLC
1596 Whitehall Road
Annapolis, MD 21409

(b) Non-Urgent Care and Post-Service Claims for services and supplies which do not require precertification must be in writing and must be submitted to the Claim Administrator using one of the following methods:

- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 792-1188

Physical Address:	**Mailing Address:**
Health Plans, Inc. **1500 West Park Drive, Suite 330** **Westborough, MA 01581**	**Health Plans, Inc.** **P.O. Box 5199** **Westborough, MA 01581**

D. Initial Claim Determination

After a claim has been submitted to Conifer or the Claim Administrator, the Plan is obligated to make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond Conifer's or the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the claimant will be notified about the need for a delay or for additional information regarding the claim within a specified period of time.

The following table shows the applicable time limits based on type and specific circumstances of the claim.

CHART A – Time Limits Regarding Initial Claims				
Type of Initial Claim	**Maximum period after receipt of claim for initial benefits determination**	**Maximum extension of initial benefits determination for delays beyond the control of Claim Administrator**	**Maximum period to notify Claimant of improperly filed claim or missing information**	**Period for Claimant to provide missing information**
URGENT CARE CLAIMS (not including urgent concurrent care claims)	72 hours	No extension permitted	24 hours	48 hours minimum*
URGENT CONCURRENT CARE CLAIMS**	24 hours	No extension permitted	24 hours	48 hours minimum*
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.
**If the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise the time limits are the same as for Urgent Care Claims.

E. How Claims are Paid

If a claim is approved, in whole or in part, and a Covered Person has authorized payments to a provider in writing, all or a portion of any eligible expenses due to a provider will be paid directly to the provider; otherwise payment will be made directly to the Covered Person. Third parties who have purchased or been assigned benefits by Physicians or other providers will *not* be reimbursed directly by the Plan.

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a claimant may file an internal appeal of the adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. Before filing an appeal, a claimant may first want to contact the Claim Administrator at (877) 234-5550 to verify that the claim was correctly processed under the terms of the Plan, but is not required to do so.

Initial internal appeals must be filed within 180 days of the initial claim denial; second internal appeals must be filed within 60 days of the initial appeal denial; requests for external review (available for rescissions and claim denials based on medical judgment) must be filed within 4 months of the second internal appeal denial. Any appeal or request for external review received after these deadlines will be denied, but note that external review of an urgent care claim may be requested simultaneously with an initial internal appeal. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

How an initial or second appeals or request for external review (if applicable) may be filed depends on the type of appeal or request for external review:

(1) Urgent Care Claim appeals or requests for external review:

(a) Urgent Care Claim appeals or requests for external review related to claims denied due to lack of Medical Necessity may be submitted verbally by calling Conifer at (877) 234-5550 or by any method available for non-urgent and post-service appeals. Upon request, Urgent Care Claim denials based on a medical judgment may be submitted for external review simultaneously with the initial appeal.

(b) Urgent Care Claim appeals or requests for external review of claims denied for any reason other than lack of Medical Necessity may be submitted verbally by calling Claim Administrator at (877) 234-5550 or by any method available for Non-Urgent Care Claim and Post-Service appeals.

(2) Non-Urgent Care Claim appeals or requests for external review, and Post-Service Care Claim appeals or requests for external review:

(a) Non-Urgent Care Claim appeals or requests for external review, and Post-Service Claim appeals or requests for external review of claims denied due to

lack of Medical Necessity must be in writing and must be submitted to Conifer using one of the following methods:

- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 792-1188

Clinical Appeals: **Physical and Mailing Address:** Conifer Value-Based Care, LLC 1596 Whitehall Road Annapolis, MD 21409	**Physical Address:** Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 **Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581

(b) Non-Urgent Care Claim appeals or requests for external review, and Post-Service Claim appeals or requests for external review of claims denied for any reason other than lack of Medical Necessity must be in writing and must be submitted to the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 792-1188

Physical Address: **Health Plans, Inc.** **1500 West Park Drive, Suite 330** **Westborough, MA 01581**	**Mailing Address:** **Health Plans, Inc.** **P.O. Box 5199** **Westborough, MA 01581**

Written appeals and requests for external review *must* include the following information:

(a) The patient's name.

(b) The patient's Plan identification number.

(c) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available).

(d) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal.

In making an appeal or request for external review, the Covered Person has the right to:

- Review pertinent documents and submit issues and comments in writing.
- Request the billing and diagnosis codes related to the claim if the Covered Person believes a coding error may have caused the denial.
- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim as soon as possible so as to provide the Covered Person with reasonable time to respond before the final internal determination is issued.
- Designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review.
- Submit written comments, documents, records, or any other matter relevant to his or her appeal or request for external review, even if the material was not submitted with the initial claim.
- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

All appeals or requests for external review will be given a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the appeal or requests for external review, regardless of whether such information was submitted or considered in the initial benefit determination. In addition, the review will not afford deference to the initial adverse benefit determination, and the review decision will be made by individuals who were not involved in the initial claim denial and who are not subordinates of those who made the initial determination. If the denial was based on a medical judgment, the appeal or requests for external review will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

If the initial appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that an initial appeal is denied, the claimant will have 60 days to request a second appeal. In filing a second appeal, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial appeal. The second appeal will be reviewed by the Plan Administrator who holds final authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits.

If the second appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that a second appeal is denied, and the denial involved a rescission or was based in whole or in part on medical

judgment, the claimant will have 4 months to request an external review. In filing a request for an external review, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial and second appeal. The Plan will conduct a preliminary review of the request to determine if the claim is eligible for external review and will provide timely notification to the claimant, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is eligible for external review, the Plan will assign the review to an IRO on a random basis, rotating assignments among IROs. The IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.

For appeals of denials based on reasons other than rescissions or medical judgment, the second internal appeal is the final appeal available to the Covered Person and there is no further review available under the Plan. However, Covered Persons may have other remedies available under state or federal law, such as filing a lawsuit.

Any legal action against the Plan must be brought within the time periods described under the General Provisions/Limitations on Actions section of this Plan Document.

CHART B Time Limits Regarding Initial and Second Internal Appeals and Request for External Review						
Type of Claim	**Maximum period for Claimant to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Claimant to file second internal appeal following denial of initial appeal in whole or in part**	**Period for Claimant to provide missing information**	**Maximum period for Claimant to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	4 months	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	180 days	15 days	60 days	15 days	4 months	45 days
POST-SERVICE CLAIMS	180 days	30 days	60 days	30 days	4 months	45 days

*available for rescissions and denials based on medical judgment

Statement of Rights

Participants in this Plan are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974. ERISA provides that all Plan participants will be entitled to:

(1) Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan documents governing the Plans including insurance contracts and collective bargaining agreements (if any) and a copy of the latest annual report (Form 5500 Series) filed, if applicable, by the Plan with the U.S. Department of Labor;

(2) Obtain, upon written request to the Plan Administrator, copies of all documents governing the operation of the Plan including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series), if applicable, and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;

(3) Receive a summary of the Plan's annual financial report if the Plan is required by law to distribute such a summary annual financial report; and

(4) Continue health care coverage for himself or herself, Spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of this Plan. The people who operate his or her plan – called "fiduciaries" of the Plan – have a duty to do so prudently and in the interest of the individual and other plan participants and beneficiaries. No one, including his or her employer, his or her union (if any), or any other person, may fire the individual or otherwise discriminate against the individual in any way to prevent the individual from obtaining benefits under the Plan or exercising his or her rights under ERISA.

If his or her claim for a benefit under this Plan is denied in whole or in part the individual must receive a written explanation of the reason for the denial. The individual has the right to have the Plan review and reconsider his or her claim. Under ERISA, there are steps the individual can take to enforce the above rights. For instance, if the individual requests materials from the Plan and does not receive them within 30 days, the individual may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay the individual up to $110 a day until the individual receives the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may file suit in a state or federal court after exhausting the internal appeals and external review process described in this Article. There may be exceptions to the requirements that individuals exhaust the internal appeals process before seeking external review or pursuing legal remedies if that Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

Any legal action against the Plan must be brought within the time periods described in the General Provisions/Limitations on Actions section of this Plan Document.

If the individual has any questions about this Plan, the individual should contact the Plan Administrator. If the individual has any questions about this statement or about his or her rights under ERISA, the individual should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in his or her telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, DC 20210.