SOUTHCOAST HEALTH SYSTEM

Health Plan

Employee Group Medical Plan

Summary Plan Description

Effective: January 1, 2011
Restated as of: January 1, 2013

www.Southcoasthealthplan.org

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A HARVARD PILGRIM COMPANY

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN,
A COMPONENT OF THE SOUTHCOAST HOSPITALS
GROUP, INC. EMPLOYEE BENEFIT PLAN
AMENDMENT #1 TO THE
RESTATED JANUARY 1, 2013 SUMMARY PLAN DESCRIPTION
EFFECTIVE: AUGUST 1, 2013

The purpose of this amendment is to revise the Plan to provide coverage for tobacco cessation products, smoking cessation intervention and BRCA testing in accordance with updated requirements of the Patient Protection and Affordable Care Act of 2010 including Women's Preventive Services; and to update the list of those classes of Employees who will have access to protected health information (PHI). 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 Plan Document and Summary Plan Description are hereby amended as follows:

SCHEDULE OF MEDICAL BENEFITS and **MEDICAL BENEFITS:**

The following sections of the **Schedule of Medical Benefits** are amended to provide coverage for the following services at the levels shown below:

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY CATAMARAN	
Prescription Drug Expense & Mail Order Option U.S. Food and Drug Administration (FDA) approved female contraceptive medications and devices are covered at 100%. **NOTE**: Tobacco cessation products are covered at 100%	**<u>Southcoast Pharmacy Prescription Drug Program – You Pay</u> (up to a 30 day supply)** 18% Coinsurance; to a minimum of $10 and maximum of $20 per generic drug 18% Coinsurance; to a minimum of $25 and maximum of $40 per preferred brand name drug 18% Coinsurance; to a minimum of $40 and maximum of $60 per non-preferred brand name drug 18% Coinsurance; to a minimum of $25 and maximum of $100 per preferred brand name specialty drug 18% Coinsurance; to a minimum of $40 and maximum of $250 per non-preferred brand name specialty drug **<u>All Other Retail Pharmacies Retail Program – You Pay</u>** (up to a 30 day supply) 20% Coinsurance; to a minimum of $10 and maximum of $20 per generic drug 20% Coinsurance; to a minimum of $25 and maximum of $40 per preferred brand name drug 20% Coinsurance; to a minimum of $40 and maximum of $60 per non-preferred brand name drug 20% Coinsurance; to a minimum of $25 and maximum of $100 per preferred brand name specialty drug 20% Coinsurance; to a minimum of $40 and maximum of $250 per non-preferred brand name specialty drug **<u>Mail Order Pharmacy – You Pay</u>** (up to a 90 day supply) 20% Coinsurance; to a minimum of $20 and maximum of $40 per generic drug; 20% Coinsurance; to a minimum of $50 and maximum of $80 per preferred brand name drug; 20% Coinsurance; to a minimum of $80 and maximum of $120 per non-preferred brand name drug. You may also obtain a 90 day supply at Southcoast Pharmacies with 18% Coinsurance, the same minimums and maximums apply Prescription Drug expenses are subject to $2,000 per person, per calendar year Prescription Drug Benefit Out-of-Pocket Maximum

PREVENTIVE CARE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.			
**** Breast Cancer Screening including Routine Mammograms and BRCA testing**	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived) for Breast Cancer Screening including Routine Mammograms 100% coverage (Deductible waived) for BRCA testing	70% coverage (after Deductible)
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived) for Smoking Cessation Counseling 100% Reasonable and Customary (Deductible waived) for Smoking Cessation Intervention (including clinics and programs)	70% coverage (after Deductible) for Smoking Cessation Counseling 100% Reasonable and Customary (Deductible waived) for Smoking Cessation Intervention (including clinics and programs)

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Genetic Testing and Related Services (Note: Coverage provided for BRCA testing – See Breast Cancer Screening in Preventive Care Services)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

SECTION V. MEDICAL BENEFITS:

C. Covered Expenses.

(1) Prescription Drugs. Prescription drug charges not covered:

Item (e) is **deleted** in its entirety and **replaced** with the following:

(e) Non-legend drugs other than insulin and tobacco cessation products

(2) Preventive Care.

Item (e) is **deleted** in its entirety and **replaced** with the following:

(e) **Breast cancer screening

Includes routine mammograms, counseling and BRCA testing for genetic susceptibility to breast cancer, and chemoprevention counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention

Item (i) is **deleted** in its entirety and **replaced** with the following:

(i) **Smoking cessation counseling and intervention (including clinics and programs)

(10) Other Services and Supplies.

Item (r) is **deleted** in its entirety and **replaced** with the following:

(r) Genetic counseling, testing and related services (See Preventive Care – Breast Cancer Screening for additional services)

Item (qq) is **deleted** in its entirety and is addressed under Preventive Care Services—see Smoking cessation counseling and intervention. All affected items in this section are re-lettered accordingly.

SECTION XI. HIPAA PRIVACY AND SECURITY PROVISIONS, is hereby deleted in its entirety and replaced with the following in order to update the list of classes of Employees or other workforce members under the control of the Plan Sponsor who may be given access to an individual's protected health information:

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:

- Director of Compensation and Benefits
- Medical Director
- Senior Vice President of Human Resources
- Vice President of Human Resources
- Human Resources Director
- Senior Benefits Analyst
- Benefits Specialist
- Human Resources Business Partner

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 Coordinator

- Human Resources Specialist
- 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.

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN
AMENDMENT #2 TO THE
RESTATED JANUARY 1, 2013 SUMMARY PLAN DESCRIPTION
EFFECTIVE: OCTOBER 1, 2013

The purpose of this amendment is to revise the Plan to change tiering for Boston Children's Hospital and provide coverage for autism spectrum disorder treatment. All references to the provisions below that appear in any part of the Summary Plan Description 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 III. DEFINITIONS and SECTION IV. SCHEDULE OF MEDICAL BENEFITS, Tier 1 and Tier 2 are hereby **deleted** in their entirety and **replaced** with the following in order to change Boston Children's Hospital and its physicians to Tier 1 providers.

Tier 1- Southcoast Hospitals & Physicians Network:

Boston Children's Hospital (MA)
Charlton Memorial Hospital (MA)
St. Luke's Hospital (MA)
Tobey Hospital (MA)

Covered high tech diagnostic imaging at Shields MRI of New Bedford, Shields MRI of Dartmouth, or New Bedford Medical Associates Central Laboratory will be paid at the Tier 1 benefit level

Tier 2-Preferred Providers:

Addison Gilbert Hospital (MA)
Alice Peck Day Memorial Hospital (NH)
Anna Jaques Hospital (MA)
Athol Memorial Hospital (MA)
Baystate Medical Center (MA)
Beth Israel Deaconess Hospital (MA)
Beth Israel Needham Campus (MA)
Beverly Hospital (MA)
Boston Medical Center (MA)
Bradley Hospital (RI)
Brockton Hospital (MA)
Butler Hospital (RI)
Cambridge Hospital (MA)
Cape Cod Hospital (MA)
Catholic Medical Center (NH)
Cheshire Medical Center (NH)
Clinton Hospital/UMASS Health System (MA)
Cottage Hospital (NH)
Dana-Farber Cancer Institute (MA)
Elliot Hospital (NH)
Emerson Hospital (MA)
Falmouth Hospital (MA)
Faulkner Hospital (MA)
Franklin Medical Center (MA)
Franklin Regional Hospital (NH)
Frisbie Memorial Hospital (NH)
Harrington Memorial (MA)
Hasbro Children's Hospital (RI)
HealthAlliance Burbank Hospital (MA)
Heywood Hospital (MA)
Holyoke Hospital Inc. (MA)
Huggins Hospital (NH)
Jordan Hospital Inc. (MA)
Kent Hospital (RI)
Lahey Medical Center (MA)
Lakes Regional General Hospital (NH)
Landmark Medical Center (RI)
Lawrence General Hospital (MA)
Lawrence Memorial Hospital (MA)
Lowell General Hospital (MA)
Marlborough Hospital (MA)
Martha's Vineyard Hospital (MA)
Mary Lane Hospital (MA)
Massachusetts Eye and Ear Infirmary (MA)
Melrose Wakefield Hospital (MA)
Memorial Hospital (RI)
Mercy Medical Center (MA)
MetroWest Medical Center (MA)
Milford Regional Hospital (MA)
Milton Hospital (MA)
Miriam Hospital (RI)
Monadnock Community Hospital (NH)
Mt. Auburn Hospital (MA)
Nantucket Cottage Hospital (MA)
New England Baptist Hospital (MA)
New London Hospital (NH)
Newport Hospital (RI)
Newton Wellesley Hospital (MA)
Noble Hospital (MA)
North Adams Regional Hospital (MA)
North Shore Medical (Salem or Union) (MA)
Parkland Medical Center (NH)
Rehabilitation Hospital of Rhode Island (RI)
Rhode Island Hospital (RI)
Roger Williams Medical Center (RI)
Saint Joseph Health Services (RI)
Saint Vincent Hospital (MA)
Saints Medical Center (MA)
Somerville Hospital (MA)
Southern New Hampshire Medical Center (NH)
South County Hospital (RI)
Speare Memorial Hospital (NH)
St. Joseph Hospital (NH)
Tufts Medical Center (MA)
The Westerly Hospital (RI)
Wentworth-Douglass Hospital (NH)
Whidden Memorial Hospital (MA)
Winchester Hospital (MA)
Wing Memorial (MA)
Women & Infants Hospital (RI)

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, Preventive Care, Routine Well Child Care is hereby **deleted** in its entirety and **replaced** with the following in order to clarify coverage for screenings.

PREVENTIVE CARE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
****Routine Well Child Care** (Including screenings, routine immunizations and flu shots)	100% coverage	$15 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, Other Services & Supplies, Autism Spectrum Disorders Treatment is hereby **added** in its entirety in order to cover treatment.

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Autism Spectrum Disorders Treatment (Including Applied Behavioral Analysis (ABA); precertification required for ABA - *see* Medical Benefits *section for limitations*) (Note: Screenings are covered under Preventive Care)	ABA and therapies: $15 Co-payment per visit then 100% coverage All other treatments: Covered according to service provided unless otherwise noted	ABA and therapies: $15 Co-payment per visit, then 100% coverage (Deductible waived) All other treatments: Covered according to service provided unless otherwise noted	ABA and therapies: $15 Co-payment per visit, then 100% coverage (Deductible waived) All other treatments: Covered according to service provided unless otherwise noted

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, Other Services & Supplies, Occupational Therapy, Physical Therapy, and Speech Therapy are hereby **deleted** in their entirety and **replaced** with the following in order to clarify Tiers 2 and 3 autism spectrum disorder treatment benefits.

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Occupational Therapy *(Precertification required after 8 visits; also see* Autism Spectrum Disorders Treatment) Up to a combined maximum of 100* visits with Physical Therapy, Speech Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Physical Therapy *(Precertification required after 8 visits; also see* Autism Spectrum Disorders Treatment) Up to a combined maximum of 100* visits with Occupational Therapy, Speech Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Speech Therapy *(Precertification required after 8 visits; also see* Autism Spectrum Disorders Treatment) Up to a combined maximum of 100* visits with Occupational Therapy, Physical Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

SECTION V. MEDICAL BENEFITS, A. Covered Expenses, (10) Other medical services and supplies, (b) Autism spectrum disorders is hereby **added** in its entirety and subsequent items are relettered accordingly.

(b) Autism Spectrum Disorders

Autism spectrum disorders treatment including habilitative or rehabilitative care, pharmacy care, psychiatric care, psychological care, or therapeutic care. Covered services include, but are not limited to, structured behavioral, Applied Behavior Analysis (ABA), occupational, physical and speech therapies, and social work services

RECEIPT OF SUMMARY PLAN DESCRIPTION

I, the undersigned, acknowledge receipt of the Summary Plan Description booklet which outlines the group medical and prescription drug benefits for myself and all of my Eligible Dependents (if any), who meet the eligibility requirements stated in this Summary Plan Description.

I further understand that my rights under the Consolidated Omnibus Budget Reconciliation Act ’85 (COBRA) for continuation of coverage and eligibility under the Special Enrollment Periods and Elections are outlined within the pages of this Summary Plan Description. By my following signature, I acknowledge receipt of the Summary Plan Description and that I am aware of my rights under COBRA and the Special Enrollment Periods and Elections.

Southcoast Hospitals Group, Inc.

_____

Employee/Pre-Age 65 Retiree Name (Please Print)

_____

Employee/Pre-Age 65 Retiree Signature

_____

Date

INDEX

I. SUMMARY PLAN DESCRIPTION

This booklet presents important information about the Southcoast Hospitals Group, Inc. Employee Group Medical Plan, a component of the Southcoast Hospitals Group, Inc. Employee Benefit Plan (Plan No. 603), effective as of January 1, 2013 (hereafter referred to as the "Plan"). The Plan is maintained by Southcoast Hospitals Group, Inc. (the "Employer") for the exclusive purpose of providing eligible Employees, their Eligible Dependents and eligible Pre-Age 65 Retirees with medical and prescription drug benefits. These 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.

This booklet and any separate benefit booklets provided to you by your employer together constitute the Summary Plan Description for your medical and prescription drug benefits under the Plan, which is intended to comply with the disclosure requirements set forth in regulations issued by the U.S. Department of Labor under the Employee Retirement Income Security Act (ERISA) of 1974. Please read this booklet carefully and keep it along with your separate benefit booklets for future reference. If you require further information or have any questions, we encourage you to contact the Human Resources Department.

On the next page of this booklet, the official Plan disclosures are provided for the Plan, along with the identity of the applicable Plan Sponsor, Plan Administrator, claims administrators and other important information required under ERISA.

The Summary Plan Description is based on a number of legal documents that may include policies, contracts, collective bargaining agreements, plan documents and trust agreements. Although the Summary Plan Description is intended to be accurate, any direct conflicts between it and the legal documents will be governed by the legal documents.

II. GENERAL INFORMATION

Plan Name:	Southcoast Hospitals Group, Inc. Employee Group Medical Plan, a component of the Southcoast Hospitals Group, Inc. Employee Benefit Plan
Type of Plan:	Welfare plan providing medical and prescription drug benefits on a self-funded basis
Effective Date:	January 1, 2011, restated as of January 1, 2013
Employer/Plan Sponsor:	Southcoast Hospitals Group, Inc. (the "Employer") 101 Page Street New Bedford, MA 02740-3464 (508) 997-1515
Plan Number:	603
Employer Identification Number:	22-2592333
Group Number:	SHP
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
Prescription Benefit Manager:	Catamaran 2441 Warrenville Road, Suite 610 Lisle, IL 60532-3642 (800) 282-3232
Case Management Services:	InforMed, LLC 1596 Whitehall Road Annapolis, MD 21409 (877) 234-5550
COBRA Administrator:	Southcoast Hospitals Group, Inc. 101 Page Street New Bedford, MA 02740-3464 (508) 997-1515
Agent for Service of Legal Process:	Employer (see above)
Plan Cost:	Contributory

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 your or your 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, 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.

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.

Actively at Work – the active expenditure of time and energy in the service of the Employer. An Employee will be deemed Actively at Work on each day of a regular paid earned time off day and on a regular non-working day on which he or she is not totally disabled, if he or she was Actively at Work on the last preceding regular working day.

Birthing Center – a facility primarily for the purpose of providing treatment for obstetrical care for which it was duly incorporated as a Birthing Center and registered as a Birthing Center with the existing state. The Birthing Center must also be licensed, if required by law.

Certificate of Coverage – a written certification provided by any source that offers medical coverage, including this Plan, for purposes of confirming the duration and type of a Covered Person's Creditable Coverage

Coinsurance – the percentage of coverage provided by the Plan, after the Covered Person has paid any applicable Deductible or Co-payment. For example, if Coinsurance is 70%, the Plan pays 70% and the Covered Person pays 30%, 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

Covered Person – an Employee, Eligible Dependent or Pre-Age 65 Retiree who is eligible for benefits and enrolled under this Plan

Creditable Coverage – coverage a Covered Person had under any of the following sources: A group health plan, health insurance coverage, Medicare, Medicaid, medical and dental care for members and former members of the Uniformed Services and their Eligible Dependents, a medical care program of the Indian Health Service or a tribal organization, a state health benefits risk pool, certain other state-sponsored arrangements established primarily to provide medical benefits to persons who have difficulty in obtaining affordable coverage because of a medical condition, a health plan offered under the Federal Employees Health Benefits Program, a public health plan, or a health benefit plan under the Peace Corps Act.

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 services before the Plan's share of the cost is determined

Eligible Dependents of Employees-

(1) An Employee's opposite- or same-sex lawful spouse as recognized in the Employee's state of residence

(2) An Employee's same-sex domestic partner when the Employee's state of residence does not recognize same-sex marriage, provided that the Employee files an Affidavit of Domestic Partnership with the Plan Administrator before requesting to enroll

If spouses or domestic partners are both Employees, each can be covered individually or as the Eligible Dependent of the other. Neither can be covered both as an Employee and as an Eligible Dependent. Only one of the two covered spouses or domestic partners may cover Eligible Dependent children, if any.

A divorced spouse or former domestic partners for whom the court-ordered terms of the divorce or termination of domestic partnership requires the Employee to provide health coverage, may remain covered under the Plan until the earliest of:

(a) The remarriage of the Employee to the extent that the Employee may cover a current spouse or an ex-spouse but may not cover both at the same time;

(b) The establishment of a new domestic partnership by the Employee to the extent that the Employee may cover a current domestic partner or a former domestic partner but may not cover both at the same time;

(c) The court-ordered termination date of coverage; or

(d) The date the Employee ceases to be a Covered Person.

(3) An Employee's child under age 26

(4) An Employee's unmarried child age 26 or older who is Permanently and Totally Disabled, whose disability began before age 26, and for whom the Employee submits proof of Permanent and Total Disability when requested at reasonable intervals

For purposes of this definition, "Permanently and Totally Disabled" means unable to engage in any substantial gainful activity by reason of a specific medically determinable physical or mental impairment which can be expected to last, or has lasted, for at least 12 months or result in death. Proof of Permanent and Total Disability must be certified by the child's Physician.

For the purposes of this section, "Employee's child" means a:

(a) Natural child of the Employee;

(b) Stepchild by marriage;

(c) Child who has been legally adopted by or placed for adoption with the Employee, or with the spouse or domestic partner by a court of competent jurisdiction;

(d) Child of a domestic partner;

(e) Child for whom legal guardianship has been awarded to the Employee or to the spouse or domestic partner by a court of competent jurisdiction; or

(f) Child who is the subject of a Qualified Medical Child Support Order (as defined below)

(i) Eligibility Due to Adoption or Placement for Adoption

Children placed for adoption with an enrolled Employee are eligible for coverage under the same terms and conditions as apply in the case of Eligible Dependent children who are natural children of enrolled Employees under the Plan, irrespective of whether or not the adoption has become final.

The terms "placement" or "being placed" for adoption with any person means the assumption and retention by such person of a legal obligation for total or partial support of such child in anticipation of the adoption. The child's placement with such person terminates upon the termination of such legal obligation.

The child's placement for adoption terminates upon the termination of such legal obligations. Upon termination of placement for adoption, the child's coverage terminates on the day the placement is terminated unless coverage must be continued pursuant to a Qualified Medical Child Support Order or continuation coverage is elected.

(ii) Eligibility Due to a Qualified Medical Child Support Order

Certain Eligible Dependents will be provided benefits in accordance with applicable requirements of any Qualified Medical Child Support Order provided that such order does not require the Plan to provide any type or form of benefit, or any option under the Plan, not otherwise provided under the Plan, except to the extent necessary to meet the requirements of law relating to medical child support described in Section 1908 of the Social Security Act (as added by Section 4301 of the Omnibus Budget Reconciliation Act of 1993). A participant may obtain a copy of the Qualified Medical Child Support Order procedures from the Plan Administrator.

Any payment of benefits made by the Plan pursuant to a Medical Child Support Order in reimbursement for expenses paid by an Alternate Recipient or an Alternate Recipient's custodial parent or legal guardian shall be made to the Alternate Recipient or the Alternate Recipient's custodial parent or legal guardian. The terms "Qualified Medical Child Support Order" and "Medical Child Support Order" shall have the meanings given to them in Section 609 of ERISA.

An "Alternate Recipient" means any child of an enrolled Employee who is recognized under a Qualified Medical Child Support Order as having a right to enroll under the Plan with respect to such Covered Person.

Note: **Tax treatment for certain dependents**. Federal tax law does not recognize former spouses, same-sex spouses, domestic partners, or their children, as dependents under the federal tax code unless the spouse, partner or child otherwise qualifies as a dependent under the Internal Revenue Code Section 152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to these Eligible Dependents as additional income to the Employee.

Employees are obligated to inform the Plan Administrator of any change in a dependent's eligibility status within 30 days of such change. In the event that an ineligible dependent is found to have received benefits under this Plan, the Employee will be responsible for any benefit payments made on that dependent's behalf.

Note: Dependents of Pre-Age 65 Retirees are not eligible for coverage under this Plan.

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.

Employee – any individual who is considered to be in an employer-employee relationship with the Employer for purposes of federal withholding taxes and who meets the eligibility requirements described in Article VII

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.

FMLA – the Family and Medical Leave Act of 1993, as amended from time to time

FMLA Leave – a leave of absence that the Employer is required to extend to an Employee under the provisions of the FMLA

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 provides 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.

Infertility – the condition of a presumably healthy individual who is unable to conceive or produce conception

Injury – a sudden event from an external agent resulting in damage 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

Late Enrollee – an Employee or Eligible Dependent who is enrolled for coverage after the initial eligibility date. Note, however, a Special Enrollee will not be considered a Late Enrollee.

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 – manic depression, 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 a current active license as a 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)

Out-of-Pocket Maximum – the maximum amount a Covered Person pays for covered services under this Plan before the Plan pays at 100% as specified on the Schedule of Medical Benefits

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-month period ending on the date shown in the General Information section

Pre-Age 65 Retiree – a former Employee between ages 60 and 65, 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, and who retired before reaching age 65. Dependents of Pre-Age 65 Retirees are not eligible to participate in this Plan.

Qualified Medical Child Support Order – A court order that meets the requirements of ERISA and provides for coverage of a child under a group health plan. An Eligible Dependent child enrolled under a QMCSO is subject to the same terms and limitations of other Covered Persons under this Plan.

Reasonable and Customary Charges – those fees for covered services that fall within the range of usual fees for comparable services charged by a medical or dental professional in a given geographic area. Reasonable and Customary Charges are based on data from a national database of medical and dental charges which is periodically updated.

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

Routine Nursery Care – routine room and board or nursery charges, Physician's or surgeon's charges, and any other related charges (including charges for circumcision) for a newborn child incurred while a patient in a Hospital, but not beyond the date the newborn child is first discharged from the Hospital

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

Significant Break in Coverage – a period of at least 63 consecutive days during all of which an Employee, Employee's Eligible Dependent or a Pre-Age 65 Retiree did not have any Creditable Coverage but does not include waiting periods or affiliation periods

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.

(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)

Special Enrollee – an Employee or his or her Eligible Dependents who satisfy the requirements of Article VII(B) for special enrollment under the Plan

Tier 1- Southcoast Hospitals & Physicians Network:

Charlton Memorial Hospital (MA)
St. Luke's Hospital (MA)
Tobey Hospital (MA)

Covered high tech diagnostic imaging at Shields MRI of New Bedford, Shields MRI of Dartmouth, or New Bedford Medical Associates Central Laboratory will be paid at the Tier 1 benefit level

Tier 2-Preferred Providers:

Addison Gilbert Hospital (MA)
Alice Peck Day Memorial Hospital (NH)
Anna Jaques Hospital (MA)
Athol Memorial Hospital (MA)
Baystate Medical Center (MA)
Beth Israel Deaconess Hospital (MA)
Beth Israel Needham Campus (MA)
Beverly Hospital (MA)
Boston Children's Hospital (MA)
Boston Medical Center (MA)
Bradley Hospital (RI)
Brockton Hospital (MA)
Butler Hospital (RI)
Cambridge Hospital (MA)
Cape Cod Hospital (MA)
Catholic Medical Center (NH)
Cheshire Medical Center (NH)
Clinton Hospital/UMASS Health System (MA)
Cottage Hospital (NH)

Dana-Farber Cancer Institute (MA)
Elliot Hospital (NH)
Emerson Hospital (MA)
Falmouth Hospital (MA)
Faulkner Hospital (MA)
Franklin Medical Center (MA)
Franklin Regional Hospital (NH)
Frisbie Memorial Hospital (NH)
Harrington Memorial (MA)
Hasbro Children's Hospital (RI)
HealthAlliance Burbank Hospital (MA)
Heywood Hospital (MA)
Holyoke Hospital Inc. (MA)
Huggins Hospital (NH)
Jordan Hospital Inc. (MA)
Kent Hospital (RI)
Lahey Medical Center (MA)
Lakes Regional General Hospital (NH)
Landmark Medical Center (RI)
Lawrence General Hospital (MA)
Lawrence Memorial Hospital (MA)
Lowell General Hospital (MA)
Marlborough Hospital (MA)
Martha's Vineyard Hospital (MA)
Mary Lane Hospital (MA)
Massachusetts Eye and Ear Infirmary (MA)
Melrose Wakefield Hospital (MA)
Memorial Hospital (RI)
Mercy Medical Center (MA)
MetroWest Medical Center (MA)
Milford Regional Hospital (MA)
Milton Hospital (MA)
Miriam Hospital (RI)
Monadnock Community Hospital (NH)
Mt. Auburn Hospital (MA)
Nantucket Cottage Hospital (MA)
New England Baptist Hospital (MA)
New London Hospital (NH)
Newport Hospital (RI)
Newton Wellesley Hospital (MA)
Noble Hospital (MA)
North Adams Regional Hospital (MA)
North Shore Medical (Salem or Union) (MA)
Parkland Medical Center (NH)
Rehabilitation Hospital of Rhode Island (RI)
Rhode Island Hospital (RI)
Roger Williams Medical Center (RI)
Saint Joseph Health Services (RI)
Saint Vincent Hospital (MA)
Saints Medical Center (MA)
Somerville Hospital (MA)
Southern New Hampshire Medical Center (NH)
South County Hospital (RI)
Speare Memorial Hospital (NH)
St. Joseph Hospital (NH)
Tufts Medical Center (MA)
The Westerly Hospital (RI)
Wentworth-Douglass Hospital (NH)
Whidden Memorial Hospital (MA)
Winchester Hospital (MA)
Wing Memorial (MA)
Women & Infants Hospital (RI)

Tier 3-Non Preferred and Out-of-Network Providers:

Androscoggin Valley Hospital (NH)
Berkshire Medical Center (MA)
Brigham & Women's Hospital (MA)
Carney Hospital (MA)
Concord Hospital (NH)
Cooley Dickinson Hospital (MA)
Duncan Lodge (RI)
Eleanor Slater Hospital (RI)
Exeter Hospital (NH)
Fairview Hospital (MA)
Good Samaritan Hospital (MA)
Holy Family Hospital (MA)
Littleton Regional Hospital (NH)
Massachusetts General Hospital (MA)
Mary Hitchcock Memorial Hospital (NH)
Memorial Hospital (NH)
Merrimack Valley Hospital (MA)
Morton Hospital (MA)
Nashoba Valley Medical Center (MA)
Norwood Hospital (MA)
Portsmouth Regional Hospital (NH)
Providence VA Medical Center (RI)
Quincy Medical Center (MA)
St. Anne's Hospital (MA)
St. Elizabeth's Hospital (MA)
South Shore Hospital (MA)
Sturdy Memorial Hospital (MA)
UMass Memorial Medical Center (MA)
Upper CT Valley Hospital (NH)
Valley Regional Hospital (NH)
Weeks Medical Center (NH)

Total Disability or Totally Disabled – the status of a covered Employee who, during any period when, as a result of Injury or Illness, is completely unable to perform the duties of any occupation for which he or she is reasonably fitted by training, education, or experience.

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

Well Child Care – treatment that is in accordance with the standards and frequencies endorsed by the United States Preventive Task Force. Coverage includes, but is not limited to; physical examinations, history, sensory screening, developmental screening and appropriate immunizations.

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. Please also refer to the section titled Medical Benefits for additional information about the benefits coverage and limitations under this Plan.

Precertification

Precertification is a process through which a Covered Person receives confirmation that benefits are payable under this Plan based on the medical necessity of the treatment recommended by or received from a health care provider. Services which require precertification are identified on the following Schedule of Medical Benefits chart, with additional information in Appendix A on specific services that require precertification.

Call InforMed at (877) 234-5550 prior to receiving services listed as requiring precertification in Appendix A of this document to confirm the Medical Necessity of the proposed services. Failure to obtain precertification will result in a reduction in benefits in the amount of $250. The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan**.**

The Plan does not cover services that precertification determines in advance are not Medically Necessary. If precertification is required but is not obtained, the Plan may not cover services that are determined not to have been Medically Necessary after they have been provided. The Plan also reserves the right to deny coverage prospectively for any service that may not require precertification if it is determined not to be Medically Necessary.

IMPORTANT

Precertification for inpatient hospitalization is required.

If a Covered Person is scheduled to be admitted to a Hospital, he or she must have the hospitalization precertified by InforMed prior to the date of admission.

The precertification requirement does not apply to maternity admissions unless it becomes apparent that the maternity admission will exceed 48 hours for a vaginal delivery or 96 hours for a cesarean delivery. In such cases, the inpatient stay that extends beyond the applicable 48 or 96 hour period must be precertified.

Primary Care Provider

This Plan generally requires the designation of a primary care provider. Any primary care provider who participates in the Plan and who is available to accept new patients may be chosen. Pediatricians may act as primary care providers for children. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact Southcoast Health Plan customer service at (877) 234-5550.

Obstetrical/Gynecological Care

No referral or precertification is needed to obtain care from a provider who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining precertification for certain services or following a pre-approved treatment plan. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Southcoast Health Plan customer service at (877) 234-5550.

Other Questions Regarding Eligibility and Benefits

Please contact the Claims Administrator at (877) 234-5550 if you have questions about Plan benefits or eligibility for covered dependents.

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.

Providers

Tier 1-Southcoast Hospital & Physicians Network

Charlton Memorial Hospital (MA)
St. Luke's Hospital (MA)
Tobey Hospital (MA)

Covered high tech diagnostic imaging at Shields MRI of New Bedford, Shields MRI of Dartmouth, or New Bedford Medical Associates Central Laboratory will be paid at the Tier 1 benefit level

Tier 2-Preferred Providers

Addison Gilbert Hospital (MA)
Alice Peck Day Memorial Hospital (NH)
Anna Jaques Hospital (MA)
Athol Memorial Hospital (MA)
Baystate Medical Center (MA)
Beth Israel Deaconess Hospital (MA)
Beth Israel Needham Campus (MA)
Beverly Hospital (MA)
Boston Children's Hospital (MA)
Boston Medical Center (MA)
Bradley Hospital (RI)
Brockton Hospital (MA)
Butler Hospital (RI)
Cambridge Hospital (MA)
Cape Cod Hospital (MA)
Catholic Medical Center (NH)
Cheshire Medical Center (NH)
Clinton Hospital/UMASS Health System (MA)
Cottage Hospital (NH)
Dana-Farber Cancer Institute (MA)
Elliot Hospital (NH)
Emerson Hospital (MA)
Falmouth Hospital (MA)
Faulkner Hospital (MA)
Franklin Medical Center (MA)
Franklin Regional Hospital (NH)
Frisbie Memorial Hospital (NH)
Harrington Memorial (MA)
Hasbro Children's Hospital (RI)
HealthAlliance Burbank Hospital (MA)
Heywood Hospital (MA)
Holyoke Hospital Inc. (MA)
Huggins Hospital (NH)
Jordan Hospital Inc. (MA)
Kent Hospital (RI)
Lahey Medical Center (MA)
Lakes Regional General Hospital (NH)
Landmark Medical Center (RI)
Lawrence General Hospital (MA)
Lawrence Memorial Hospital (MA)
Lowell General Hospital (MA)
Marlborough Hospital (MA)
Martha's Vineyard Hospital (MA)
Mary Lane Hospital (MA)
Massachusetts Eye and Ear Infirmary (MA)
Melrose Wakefield Hospital (MA)
Memorial Hospital (RI)
Mercy Medical Center (MA)
MetroWest Medical Center (MA)
Milford Regional Hospital (MA)
Milton Hospital (MA)
Miriam Hospital (RI)
Monadnock Community Hospital (NH)
Mt. Auburn Hospital (MA)
Nantucket Cottage Hospital (MA)
New England Baptist Hospital (MA)
New London Hospital (NH)
Newport Hospital (RI)
Newton Wellesley Hospital (MA)
Noble Hospital (MA)
North Adams Regional Hospital (MA)
North Shore Medical (Salem or Union) (MA)
Parkland Medical Center (NH)
Rehabilitation Hospital of Rhode Island (RI)
Rhode Island Hospital (RI)
Roger Williams Medical Center (RI)
Saint Joseph Health Services (RI)
Saint Vincent Hospital (MA)
Saints Medical Center (MA)
Somerville Hospital (MA)
Southern New Hampshire Medical Center (NH)
South County Hospital (RI)
Speare Memorial Hospital (NH)
St. Joseph Hospital (NH)
Tufts Medical Center (MA)
The Westerly Hospital (RI)
Wentworth-Douglass Hospital (NH)
Whidden Memorial Hospital (MA)
Winchester Hospital (MA)
Wing Memorial (MA)
Women & Infants Hospital (RI)

Tier 3-Non Preferred and Out-of-Network Providers

Androscoggin Valley Hospital (NH)
Berkshire Medical Center (MA)
Brigham & Women's Hospital (MA)
Carney Hospital (MA)
Concord Hospital (NH)
Cooley Dickinson Hospital (MA)
Duncan Lodge (RI)
Eleanor Slater Hospital (RI)
Exeter Hospital (NH)
Fairview Hospital (MA)
Good Samaritan Hospital (MA)
Holy Family Hospital (MA)
Littleton Regional Hospital (NH)
Massachusetts General Hospital (MA)
Mary Hitchcock Memorial Hospital (NH)
Memorial Hospital (NH)
Merrimack Valley Hospital (MA)
Morton Hospital (MA)
Nashoba Valley Medical Center (MA)
Norwood Hospital (MA)
Portsmouth Regional Hospital (NH)
Providence VA Medical Center (RI)
Quincy Medical Center (MA)
St. Anne's Hospital (MA)
St. Elizabeth's Hospital (MA)
South Shore Hospital (MA)
Sturdy Memorial Hospital (MA)
UMass Memorial Medical Center (MA)
Upper CT Valley Hospital (NH)
Valley Regional Hospital (NH)
Weeks Medical Center (NH)

To find a participating provider and the provider's tier designation go to www.southcoasthealthplan.org or call (877) 234-5550.

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY CATAMARAN	
Prescription Drug Expense & Mail Order Option U.S. Food and Drug Administration (FDA) approved female contraceptive medications and devices are covered at 100%.	**Southcoast Pharmacy Card Program – You Pay** (up to a 30 day supply) 18% Coinsurance; to a minimum of $10 and maximum of $20 per generic drug 18% Coinsurance; to a minimum of $25 and maximum of $40 per preferred brand name drug 18% Coinsurance; to a minimum of $40 and maximum of $60 per non-preferred brand name drug 18% Coinsurance; to a minimum of $25 and maximum of $100 per preferred brand name specialty drug 18% Coinsurance; to a minimum of $40 and maximum of $250 per non-preferred brand name specialty drug **All Other Retail Pharmacies Retail Card Program – You Pay** (up to a 30 day supply) 20% Coinsurance; to a minimum of $10 and maximum of $20 per generic drug 20% Coinsurance; to a minimum of $25 and maximum of $40 per preferred brand name drug 20% Coinsurance; to a minimum of $40 and maximum of $60 per non-preferred brand name drug 20% Coinsurance; to a minimum of $25 and maximum of $100 per preferred brand name specialty drug 20% Coinsurance; to a minimum of $40 and maximum of $250 per non-preferred brand name specialty drug **Mail Order Pharmacy – You Pay** (up to a 90 day supply) 20% Coinsurance; to a minimum of $20 and maximum of $40 per generic drug 20% Coinsurance; to a minimum of $50 and maximum of $80 per preferred brand name drug 20% Coinsurance; to a minimum of $80 and maximum of $120 per non-preferred brand name drug You may also obtain a 90 day supply at Southcoast Pharmacies with 18% Coinsurance, the same minimums and maximums apply Prescription Drug expenses are subject to $2,000 calendar year Prescription Drug Benefit Out-of-Pocket Maximum

DEDUCTIBLES/COINSURANCE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Calendar Year Deductible*	NONE per person NONE per employee +1 NONE per family	$500 per person $1,000 per employee +1 $1,000 per family	$1,000 per person $2,000 per employee +1 $2,000 per family
***Note: The family Deductible amount is satisfied by a combination of all family members. However, no more than the per person Deductible will apply to one family member's expenses.**			
Reimbursement Percentage ("Coinsurance")	100% of the fee schedule amount (unless otherwise stated)	100% of the fee schedule amount (after Deductible; unless otherwise stated)	70% of the Reasonable & Customary charge or the Harvard Pilgrim Health Care allowance, whichever applies (after Deductible; unless otherwise stated) until the Out-of-Pocket maximum has been reached, then 100% thereafter for the balance of the calendar year (unless otherwise stated)
Out-of-Pocket Maximums* (Including the Calendar Year Deductible)	Combined with Tier 2 Combined with Tier 2 Combined with Tier 2	$2,000 per person $4,000 per employee +1 $4,000 per family	$2,500 per person $5,000 per employee +1 $5,000 per family

***Note: The family Out-of-Pocket maximum is satisfied by a combination of all family members. However, no more than the per person Out-of-Pocket Maximum will apply to one family member's expenses.**

The Tiers 2 and 3 Deductibles and Out-of-Pocket maximums are combined. Eligible Tier 2 expenses which track toward the Tier 2 Deductible and Out-of-Pocket Maximum will be credited toward satisfaction of Tier 3 Deductible and Out-of-Pocket maximums and vice versa.

The following expenses are included in the Medical Plan Out-of-Pocket Maximums:

- Emergency room Co-payments
- Deductibles and Coinsurance

The following expenses are excluded from the Medical Plan Out-of-Pocket Maximums:

- Office visit Co-payments
- Prescription drug Co-payments and Coinsurance (these expenses are included in the Prescription Drug Benefit Out-of-Pocket Maximum)
- Any other Co-payment not specifically listed as included
- Precertification penalties

The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charges or the HPHC fee schedule, whichever applies, when services are rendered by a Tier 3 Provider.

PREVENTIVE CARE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.			
****Routine Physical Exams** (Including routine immunizations and flu shots)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Well Child Care** (Including routine immunizations and flu shots)	100% coverage	$15 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Breastfeeding Support and Counseling** (During pregnancy and/or in the post partum period) ****Breastfeeding Supplies** (Rental or purchase of breastfeeding equipment) <u>Breast Pump Limits</u>: • Hospital Grade Breast Pumps: rental covered up to 3 months (*precertification required* for rental in excess of 3 months) • Electric Breast Pumps: rent or purchase, whichever is less; • Manual Breast Pumps: purchase	100% coverage NOT AVAILABLE	100% coverage (Deductible waived) 100% coverage (Deductible waived)	70% coverage (after Deductible) 70% coverage (after Deductible)
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Pap Smears**	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
**** Breast Cancer Screening including Routine Mammograms** (Age 40 and older)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

PREVENTIVE CARE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.			
One Baseline Mammogram (Between age 35 and 39)	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Immunizations** (If not billed with an office visit; includes flu shots)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Lab, X-rays, and Clinical Tests** (Including pregnancy tests and those related to maternity care)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies**	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
****Nutritional Counseling**	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Smoking Cessation Counseling**	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Routine Hearing Exam Up to a maximum of one (1)* exam per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Routine Prostate Exam and Prostate-Specific Antigen (PSA) Screening (age 40 and older) Up to a maximum of one (1)* per person, per calendar year	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

PREVENTIVE CARE	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.			
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to a maximum of one (1)* per person, per lifetime	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
****Bone Density Screening**	100% coverage	$25 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Preventive Pediatric Dental – up to age 12 Including: • One (1) initial exam per covered child, • One (1) periodic exam every six (6) months per covered child, • One (1) cleaning every six (6) months per covered child, • One (1) fluoride treatment every six (6) months per covered child, and • One (1) set of bitewing x-rays ever six (6) months per covered child	NOT AVAILABLE	NOT AVAILABLE	100% coverage (Deductible waived)
VISION CARE			
Routine Vision Exam (Includes contact lens fitting) Up to a maximum of one (1)* exam per person, per calendar year	$30 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Eyewear (Contact lenses needed to treat keratoconus (including the fitting of these contact lenses); and intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

DOCTOR SERVICES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Allergy Testing	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Allergy Treatment	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Anesthesia (In/Outpatient)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Audiology	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Chiropractic Services	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Colonoscopy (Non Routine)	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Maternity (Includes delivery, prenatal and postpartum care)	100% coverage	100% coverage (Deductible waived) $30 Co-payment for initial visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Physician Hospital Visits	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Physician Office Visits (Includes all related charges billed at time of visit)	Pediatrician: $15 Co-payment per visit then 100% coverage Primary Care Physician: $15 Co-payment per visit then 100% coverage Specialist: $25 Co-payment per visit, then 100% coverage	Pediatrician: $20 Co-payment per visit, then 100% coverage (Deductible waived) Primary Care Physician: $30 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

DOCTOR SERVICES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Second or Third Surgical Opinion (Third Surgical Opinion if second opinion differs from the first opinion)	$15 Co-payment per visit, 100% coverage	$30 Co-payment per visit, 100% coverage (Deductible waived)	70% coverage (after Deductible)
Surgery (Inpatient; *precertification required)*	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Surgery (Outpatient; *precertification may be required; see Appendix A)*	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Surgery (Physician's office; *precertification may be required; see Appendix A)*	Primary Care Physician: $15 Co-payment per visit, then 100% coverage Specialist: $25 Co-payment per visit, then 100% coverage	Primary Care Physician: $30 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
HOSPITAL SERVICES – INPATIENT			
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty. Procedures that are not Medically Necessary will not be covered.			
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Maternity Services Semi-private room or special care unit	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Birthing Center	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

HOSPITAL SERVICES – INPATIENT	**SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1**	**PREFERRED PROVIDERS TIER 2**	**NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3** (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty. Procedures that are not Medically Necessary will not be covered.			
Organ, Bone Marrow and Stem Cell Transplants (*Precertification required; see* Medical Benefits *section for other limitations)* Semi-private room or special care unit	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Surgical Facility & Supplies	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Miscellaneous Hospital Charges	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
HOSPITAL SERVICES – OUTPATIENT			
Certain outpatient procedures require precertification at (877) 234-5550. Failure to pre-certify may result in a $250 penalty. Procedures that are not Medically Necessary will not be covered.			
Clinic Services (At a Hospital)	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) **Inpatient Admission directly from the Emergency Room** (Inpatient admission to a Tier 2 or 3 facility when transported directly from a Southcoast facility due to an emergency will be covered as a Tier 1 admission.)	$100 Co-payment per visit, then 100% coverage (Co-payment is waived if admitted as an inpatient) 100% coverage	$100 Co-payment per visit, then 100% coverage (Deductible waived; inpatient Co-payment applies if admitted) 100% coverage (after Deductible)	$100 Co-payment per visit, then 100% coverage (Deductible waived; inpatient Co-payment applies if admitted) 100% coverage (after Tier 2 Deductible)
Esophagogastroduodenoscopy (EGD)	100% coverage	100% coverage *(*after Deductible; *precertification required)*	70% coverage (after Deductible; *precertification required)*
Outpatient Department	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

HOSPITAL SERVICES – OUTPATIENT	**SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1**	**PREFERRED PROVIDERS TIER 2**	**NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3** (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Certain outpatient procedures require precertification at (877) 234-5550. Failure to pre-certify may result in a $250 penalty. Procedures that are not Medically Necessary will not be covered.			
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. *(Precertification required)*	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Preadmission Testing	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Student Health Centers	$30 Co-payment per visit, then 100% coverage (Deducible waived)		
Urgent Care Facility/Walk-In Clinic	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
MENTAL HEALTH/ SUBSTANCE ABUSE			
Inpatient hospitalizations require precertification at (877) 234-5550. Failure to pre-certify may result in a $250 penalty. Procedures that are not Medically Necessary will not be covered.			
Inpatient/Partial Hospitalization/ Intensive Outpatient Programs *(Precertification required)*	100% coverage	100% coverage (Deductible waived)	100% coverage (Deductible waived)
Inpatient Physician Visit	100% coverage	100% coverage (Deductible waived)	100% coverage (Deductible waived)
Hospital Clinic Visit	$15 Co-payment per visit, then 100% coverage	$15 Co-payment per visit, then 100% coverage (Deductible waived)	$15 Co-payment per visit, then 100% coverage (Deductible waived)
Office Visit	$15 Co-payment per visit then 100% coverage	$15 Co-payment per visit, then 100% coverage (Deductible waived)	$15 Co-payment per visit, then 100% coverage (Deductible waived)
OTHER SERVICES & SUPPLIES			
Ambulance Services (*See* Medical Benefits *section for limitations*)	100% coverage	100% coverage (Deductible waived)	100% coverage (Deductible waived)
Bariatric Surgery (When related to treatment of Morbid Obesity; *precertification required*)	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Biofeedback	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Cardiac Rehabilitation/Pulmonary Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Chemotherapy & Radiation Therapy *(Precertification required)*	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Cleft Lip/Palate Repair/Treatment (Includes medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry, speech therapy, audiology, and nutrition services; *precertification required ; see* Medical Benefits *section for limitations*)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Cochlear Implants *(Precertification required)*	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Dental Surgery (Includes excision of impacted wisdom teeth; *precertification required except for excision of impacted wisdom teeth*; *see* Medical Benefits *section for other limitation*)	100% coverage	Dentist's Office: 100% coverage (Deductible waived) Outpatient Surgical Facility: 100% coverage (after Deductible)	70% coverage (after Deductible)
Diabetes Self-Management Training and Education	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Diagnostic X-ray and Laboratory (Outpatient)	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Durable Medical Equipment (*Precertification required for equipment in excess of $1,500, rentals exceeding 3 months, and TENS units must be pre-certified; see* Medical Benefits *section for other limitations*)	NOT AVAILABLE	80% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Early Intervention Services (To age 3; s*ee* Medical Benefits *section for limitations*)	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Elective Termination of Pregnancy	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Erectile Dysfunction Treatment (Limited to treatment of a medical condition or treatment of erectile dysfunction as a consequence of medical treatment)	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Family Planning (Including, but not limited to: consultations and diagnostic tests) **For Women** (See also Prescription Drug Benefit and Preventive Care Section) **For Men**	100% coverage $15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived) $30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible) 70% coverage (after Deductible)
Genetic Counseling	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Genetic Testing and Related Services	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Growth Hormones *(Precertification required)*	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Hearing Aids and Related Services (Including services prescribed by an audiologist or hearing instrument specialist, initial evaluation, fitting and adjustments, ear molds, batteries, and other related supplies; one (1)* hearing aid per hearing-impaired ear every 36 months to $2,000 per device to age 21)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Hemodialysis *(Precertification required)*	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
High Tech Diagnostic Imaging (MRI, CT Scan, PET Scan)	100% coverage	100% coverage (after Deductible; *precertification required for MRIs/MRAs, nuclear cardiology services, and PET/CAT scans)*	70% coverage (after Deductible; *precertification required for MRIs/MRAs, nuclear cardiology services, and PET/CAT scans)*
Home Health Care (*Precertification required after 8 visits*)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Hospice Care (*Precertification required*; *see* Medical Benefits *section for other limitations*)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Infertility Treatment (*See* Medical Benefits *section for other limitations*) Up to a maximum of three (3)* unsuccessful cycles per person, per lifetime. However, if pregnancy occurs and results in viability through the first trimester (12 weeks), three (3)* more cycles are permitted with an approved treatment plan from InforMed.	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Injectables (Home infusion therapy requires precertification)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Learning Deficiencies/Behavioral Problems/Developmental Delay	$15 Co-payment, then 100% coverage	$30 Co-payment, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Mastectomy & Reconstructive Surgery	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Medical and Enteral Formula (Including metabolic formula; s*ee* Medical Benefits *section for other limitations*) Up to a combined maximum of $5,000* with Modified Low Protein Food Products per person, per calendar year	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Modified Low Protein Food Products (*See* Medical Benefits *section for other limitations*) Up to a combined maximum of $5,000* with Medical and Enteral Formula per person, per calendar year	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Occupational Therapy *(Precertification required after 8 visits*) Up to a combined maximum of 100* visits with Physical Therapy, Speech Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Other Medical Supplies (Including diabetic supplies, ostomy and colostomy supplies)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Orthotics *(Purchases of $1,500 or more must be pre-certified*)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Pain Management Injections Performed in an office or clinic setting *(Precertification required)* Performed in a surgical facility or outpatient department of a hospital *(Precertification required)*	Primary Care Physician: $15 Co-payment per visit then 100% coverage Specialist: $25 Co-payment per visit, then 100% coverage 100% coverage	Primary Care Physician: $30 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $40 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Deductible)	70% coverage (after Deductible) 70% coverage (after Deductible)
Physical Therapy *(Precertification required after 8 visits*) Up to a combined maximum of 100* visits with Occupational Therapy, Speech Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Podiatry Care (*See* Medical Benefits *section for limitations*)	$25 Co-payment per visit, then 100% coverage	$40 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	**SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1**	**PREFERRED PROVIDERS TIER 2**	**NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3** (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Prosthetics *(Purchases of $1,500 or more must be pre-certified*; see *Medical Benefits* section for other limitations)	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Rehabilitation Hospital *(Precertification required*; *see* Medical Benefits *section for other limitations*) Up to a maximum of 60* inpatient days per person, per calendar year	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Respiratory/Pulmonary Therapy	100% coverage	100% coverage (Deductible waived)	70% coverage (after Deductible)
Skilled Nursing Facility/Extended Care Facility *(Precertification required*; *see* Medical Benefits *section for other limitations*) Up to a maximum of 100* inpatient days per person, per calendar year	NOT AVAILABLE	100% coverage (after Deductible)	70% coverage (after Deductible)
Smoking Cessation Therapy (In addition to smoking cessation counseling in the primary care setting-see Preventive Services) Up to a maximum of three (3)* months per person, per calendar year	100% coverage	100% coverage (Deductible waived)	100% coverage (Deductible waived)
Speech Therapy *(Precertification required after 8 visits*) Up to a combined maximum of 100* visits with Occupational Therapy, Physical Therapy, and TMJ per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)
Temporomandibular Joint Disorders (TMJ) Treatment *(Precertification required after 8 Physical Therapy visits*) Up to a combined maximum of 100* visits with Occupational Therapy, Physical Therapy, and Speech Therapy per person, per calendar year	$15 Co-payment per visit, then 100% coverage	$30 Co-payment per visit, then 100% coverage (Deductible waived)	70% coverage (after Deductible)

***These maximums are combined Tiers 1, 2, and 3 maximums.**

OTHER SERVICES & SUPPLIES	SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK TIER 1	PREFERRED PROVIDERS TIER 2	NON-PREFERRED AND OUT-OF-NETWORK PROVIDERS TIER 3 (All services are based on Reasonable and Customary Charges or the HPHC fee schedule, whichever applies)
Voluntary Sterilization			
For Women	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
For Men	100% coverage	100% coverage (after Deductible)	70% coverage (after Deductible)
Wigs (When hair loss is due to chemotherapy, radiation therapy, infections, burns, traumatic injury, congenital baldness, or medical conditions resulting in *alopecia areata* or *alopecia totalis* (*capitus*) Up to a maximum of $500* per person, per calendar year	100% coverage	100% coverage (Deductible waived)	100% coverage (Deductible waived)
WELLNESS BENEFITS	**ALL PROVIDERS**		
Childbirth Classes (*See* Medical Benefits *section for limitations*)	First childbirth course: 100% coverage (Deductible waived) up to a maximum of $90 for each covered expectant mother. Refresher childbirth course: 100% coverage (Deductible waived) up to a maximum of $45 for each covered expectant mother.		
Fitness Reimbursement Benefit	100% coverage (Deductible waived) up to a total reimbursement of $150 per family, per calendar year for health club membership fees. (Must be paid in the current calendar year for membership in that year and the paid date must be within your dates of enrollment in this Plan. You must be a member of a qualified, full-service health and fitness club with cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness for at least four (4) consecutive months and have been on this plan for at least four (4) consecutive months to be eligible for reimbursement.)		

***These maximums are combined Tiers 1, 2, and 3 maximums.**

Overall Plan Year Benefit Maximum: Unlimited

V. MEDICAL BENEFITS

A. Benefit Levels

Tier 1 Providers

If a Covered Person has incurred covered medical expenses and services are rendered by a Tier 1 Provider, the Plan will pay the Reimbursement Percentage as shown in the Schedule of Medical Benefits.

Tier 2 Providers

If a Covered Person has incurred covered medical expenses and services are rendered by a Tier 2 Provider, the Plan will pay the Reimbursement Percentage (after satisfaction of the calendar year Deductible) as shown in the Schedule of Medical Benefits.

Tier 3 Providers

If a Covered Person has incurred covered medical expenses and services are rendered by a Tier 3 Provider, the Plan will pay the Reimbursement Percentage (after satisfaction of the calendar year Deductible) as shown in the Schedule of Medical Benefits subject to Reasonable and Customary Charges or the Harvard Pilgrim Health Care (HPHC) fee schedule, whichever applies.

Tier 3 Providers will be paid at Tier 1 or Tier 2 Provider levels subject to Reasonable and Customary Charges or the HPHC fee schedule, whichever applies, when ancillary medical services are rendered to a Covered Person on an inpatient or outpatient basis in a Tier 1 or Tier 2 Hospital or facility. In addition, Tier 2 and Tier 3 Providers will be paid at Tier 1 Provider Co-payment and Coinsurance levels in the case of "Emergency Care" as defined in the section titled "Definitions" when transferred from a Tier 1 facility. Ancillary medical services include the following types of professional services: anesthesia, radiology and pathology, as well as covered services provided by non-admitting consulting physicians.

Traveling Benefit

If a Covered Person is traveling out of state or out of country and requires medical treatment from a non-network provider (excluding when a Covered Person traveled to such location for the primary purpose of obtaining medical services, drugs or supplies), benefits shall be payable at Tier 2 Provider levels subject to Reasonable and Customary Charges.

Deductible

There is no Deductible that applies to services provided by a Tier 1 Provider. With respect to a Covered Person, the Deductible for services rendered by Tier 2 or Tier 3 Providers in each calendar year shall be as shown in the Schedule of Medical Benefits.

Any number of family members may help to meet the family Deductible, but no more than the per person Deductible will apply to one family member's expenses.

The Tiers 2 and 3 Deductibles are combined. Eligible Tier 2 expenses which track toward the Tier 2 Deductible will be credited toward satisfaction of Tier 3 Deductible and vice versa.

Single Accident Deductible

If two or more Covered Persons in the same family are injured in a common accident, the Deductible applicable in the calendar year of the common accident for Covered Expenses related to that accident incurred by all family members shall be limited to a single per person Deductible for that calendar year.

Out-of-Pocket Maximum

The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits.

Prescription Drug Benefit

Prescription Drug Benefit
The Out-of-Pocket Maximum includes prescription drug Co-payments and Coinsurance. The Out-of-Pocket Maximum excludes any other Co-payments, Coinsurance, Deductible, penalty, or fee not specifically listed as included.

Medical Plan

The Out-of-Pocket Maximum includes emergency room Co-payments; Deductibles; and Co-insurance. The Out-of-Pocket Maximum excludes charges in excess of the Reasonable and Customary Charges or the Harvard Pilgrim Health Care fee schedule, when applicable; Office visit Co-payments; prescription drug Co-payments and Coinsurance; any other Co-payments not specifically listed as included; and any penalties for failure to follow Precertification Requirements.

Any number of family members may help to meet the family Out-of-Pocket Maximums but no more than the per person Out-of-Pocket Maximum will apply to one family members expenses.

The Tiers 2 and 3 Out-of-Pocket Maximums are combined. Eligible Tier 2 expenses which track toward the Tier 2 Out-of-Pocket Maximum will be credited toward satisfaction of Tier 3 Out-of-Pocket Maximums and vice versa.

B. Complex Case Management/Alternate Treatment Coverage

If a Covered Person's condition is, or is expected to become, serious and complex in nature, the Plan Administrator may arrange for review and/or case management services from a professional qualified organization. The purpose of the case management service

is to help plan necessary, quality care in the most cost-effective manner with the approval and cooperation of the Covered Person, family and attending Physician(s). This is a voluntary service to help manage both care and cost of a potentially high-risk or long term medical condition, and neither Covered Persons nor treating Physicians are required to participate in complex case management.

If a case is identified as appropriate for complex case management, then the case management organization will contact the treating Physician(s) and Covered Person to develop and implement a mutually agreeable treatment plan. If either the attending Physician or the Covered Person does not wish to follow the treatment plan, benefits will continue to be paid as stated in the Plan.

If the Physician(s) and Covered Person agree to the treatment plan, in some cases services not normally covered by the Plan may be eligible for coverage. If it appears that the most appropriate and cost-effective care will be rendered in a setting or manner not usually covered under the terms of the Plan, such care may be covered under the auspices of a complex case management treatment plan. In such cases, all Medically Necessary services included in the approved treatment plan will be covered under the terms of the Plan. However, the coverage of services under a complex case management plan that are not otherwise covered under this Plan does not set any precedent or create any future liability for coverage of such services with respect to either the Covered Person who is the subject of the plan or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

C. Covered Expenses

Under this Plan, the term "covered expense" refers to the fee schedule amount for Tier 1 and Tier 2 Providers or, for Tier 3 Providers, the Reasonable and Customary Charge or the HPHC fee schedule, whichever applies, for services prescribed by a Physician and expenses incurred for medical treatment of an Illness or Injury. Covered expenses are subject to the calendar year Deductible, Coinsurance, Co-payments and other limits as shown in the Schedule of Medical Benefits for the following:

(1) Prescription Drugs

Expenses for covered prescription drugs and medicines will be covered as described in the section titled "Schedule of Medical Benefits" through Southcoast pharmacy, retail pharmacies and Catamaran's mail order program.

The benefits are payable for Medically Necessary prescription drugs ordered in writing by a Physician or other Provider as allowed by law for treatment of a Covered Person up to a 30-day supply for each prescription or refill (31 – 90-day supply for each prescription or refill through Southcoast pharmacy or the mail order plan), unless customarily dispensed in 100 unit dose quantities.

<u>Prescription drug charges not covered</u>:

(a) Drugs dispensed by any person not licensed to dispense drugs;

(b) Administration of drugs;

(c) Drugs labeled “Caution Limited by Federal Law for Investigational Use”;

(d) Drugs administered and consumed at the time and place of the prescription issue;

(e) Non-legend drugs other than insulin;

(f) Therapeutic devices or appliances, support garments and other non-medical substances;

(g) Investigational or experimental drugs; including compounded medications for non-FDA-approved use;

(h) Prescriptions which an eligible person is entitled to receive without charge from any Worker’s Compensation laws, or any municipal, state or federal program;

(i) Acne medication, age 35 and over;

(j) Erectile dysfunction medication in excess of six (6) units per month (excluded for Covered Persons age 18 and younger);

(k) Abortifacient drugs

Note: The following drugs are available though the Prescription Drug Benefit but are excluded from coverage under the Medical Plan; Enbrel (J1438), Humate-p (J7187), Humira (J0135), Kogenate FS (J7190), Neulasta (J2505), Neumega (J2355), Neupogen (J1440), Neupogen (J1441), and Orencia (J0129).

(2) Preventive Care

The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Specific services may be covered based on the recommended frequency, age and gender. For additional detail about the coverage levels, please go to www.HealthCare.gov.

(a) **Routine physicals

Routine adult physical examinations including all related charges tests billed at the time of visit, including, but not limited to x-rays, laboratory and clinical tests and routine immunizations. Covered services include, but are not limited to those listed at http://www.healthcare.gov/law/about/provisions/services/lists.

(b) **Routine Well Child Care

Routine Well Child Care including all charges billed at the time of visit, including, but not limited to physical examinations, history, sensory screening and neuropsychiatric evaluation, appropriate immunizations and fluoride to age 5. Covered services include, but are not limited to those listed at http://www.healthcare.gov/law/about/provisions/services/lists.

(c) Women's Preventive Services

Services include, but are not limited to, gestational diabetes screenings, human papillomavirus (HPV) testing, counseling for sexually transmitted infections, human immunodeficiency virus (HIV) and domestic violence screenings and counseling. Covered services include, but are not limited to those listed at http://www.healthcare.gov/law/resources/regulations/womensprevention.html:

(i) Breastfeeding support, supplies and counseling by a trained provider during pregnancy and/or in the postpartum period and costs for renting/purchasing breastfeeding equipment; coverage for breast pumps, includes hospital grade, electric, or manual;

(ii) Contraception and contraceptive counseling including all FDA approved prescription contraceptive methods, sterilization procedures, and patient education and counseling for all women with reproductive capacity;

(iii) Well-woman visits to obtain recommended preventive services that are age and developmentally appropriate, including preconception and prenatal care; services are provided annually or as recommended

(d) **Routine gynecological/obstetrical care

Includes preconception and prenatal services; ovarian cancer screening; cervical cancer screening, including Pap smear

(e) **Breast cancer screening

Includes routine mammograms, counseling for genetic susceptibility to breast cancer, and chemoprevention counseling for women at high risk for breast cancer and low risk for adverse effects of chemoprevention

(f) **Routine lab, x-rays and clinical tests

(g) **Routine colorectal cancer screening

Includes fecal occult screening, sigmoidoscopy and colonoscopy

(h) **Nutritional counseling

(i) **Smoking cessation counseling

(j) Routine hearing exam

(k) Routine prostate exam

Includes Prostate-Specific Antigen (PSA) screening

(l) **Abdominal aortic aneurysm screening

(m) **Bone Density screening

(n) Pediatric dental care

(3) Vision Care

(a) Routine vision exam including contact lens fittings

(b) Contact lenses needed to treat keratoconus including the fitting of these contact lenses

(c) Intraocular lenses implanted after corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced

(4) Physician Services

(a) Allergy testing and treatment, including preparation of serum and injections

(b) Anesthesia (In/outpatient)

(c) Audiology

(d) Chiropractic services from a licensed provider

(e) Colonoscopy (non routine)

(f) Maternity

Includes delivery, prenatal and postpartum care of mother and fetus

Amniocentesis is included if deemed Medically Necessary. No benefits will be payable if amniocentesis is performed only to determine the sex of an infant before birth and for women under age thirty-five (35) unless certified as Medically Necessary by a Physician.

(g) 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.

(h) Physician office visits

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

(i) Second surgical opinion and, in some instances, a third opinion as follows:

Fees of a legally qualified Physician for a second surgical consultation when non-emergency or elective surgery is recommended by the Covered Person's attending Physician. The Physician rendering the second opinion regarding the Medical Necessity of such surgery must be qualified to render such a service, either through experience, specialization training, education, or similar criteria, and must not be affiliated in any way with the Physician who will be performing the actual surgery; and

Fees of a legally qualified Physician for a third consultation, if the second opinion obtained does not concur with the first Physician's recommendation. This third Physician must be qualified to render such a service and must not be affiliated in any way with the Physician who provided the second opinion or with the Physician who will be performing the actual surgery.

(j) Surgery (inpatient/outpatient/office)

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

If two or more surgical procedures are performed at one time through the same incision in the same operative field, the maximum allowable amount for the surgery will be either the fee schedule amount for the primary procedure and 50% of the fee schedule amount for the secondary or lesser procedure(s), or if in Tier 3, the Reasonable and Customary Charge or the HPHC fee schedule, whichever applies, for the major procedure and 50% of the Reasonable and Customary Charge or the HPHC fee schedule, whichever applies, for the secondary or lesser procedure(s). No additional benefit will be paid under this Plan for incidental surgery done at the same time and under the same anesthetic as another surgery.

The Plan will also pay for a surgical assistant when the nature of the procedure is such that the services of an assistant Physician are Medically Necessary.

Surgical procedures include circumcision, termination of pregnancy, vasectomies and tubal ligations, but not reverse sterilization.

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital room and board for a semiprivate room, intensive care unit, cardiac care unit or burn care unit, but excluding charges for a private room (unless determined to be Medically Necessary or the Hospital has only private rooms) which are in excess of the Hospital's semiprivate room rate.

(b) Maternity services

Inpatient care for the mother and/or newborn child will be provided for a minimum of 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section. However, the mother's or newborn's attending Physician, after consulting with the mother, may discharge the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

Note: If the mother chooses to be discharged earlier, coverage is provided for one (1) home visit by a Physician, registered nurse, nurse midwife or nurse practitioner within 48 hours of discharge. This visit may include: parent education, assistance and training in breast or bottle feeding, and appropriate tests. Additional visits will be covered only if precertified by InforMed.

(c) Birthing Center

Birthing center or freestanding health clinic services, with benefits limited to the amount that would have been paid if the Covered Person were in a Hospital

(d) Newborn care

Routine nursery care (including circumcision and Physician's visits) while confined even though no Illness or Injury exists

(e) 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.

These benefits will be provided subject to the same Deductibles and Coinsurance applicable to other medical and surgical benefits provided under this Plan.

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

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.

If the donor is covered under the Plan, eligible charges will be covered.

If the recipient is covered under the Plan, but the donor is not, the Plan will provide coverage to both the recipient and donor as long as similar benefits are not available to the donor from other coverage sources.

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

Transportation: Transportation to and from the site of the covered organ transplant procedure for the recipient and one other individual, or in the event that the recipient or the donor is a minor, two (2) other individuals. In addition, all reasonable and necessary lodging and meal expenses incurred during the Transplant Benefit Period will be covered.

Re-transplantation: Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime.

(g) Charges for cosmetic purposes or for cosmetic surgery are covered if due solely to:

Bodily Injury, providing that coverage is in effect at the time treatment occurs;

Birth defect of a Covered Person, provided coverage is in effect at the time treatment occurs; or

Surgical removal of diseased tissue as a result of an Illness. Covered Persons electing breast reconstruction, following a mastectomy, are also covered for reconstruction of the other breast to produce symmetrical appearance, and coverage for prostheses and physical complications of all stages of a mastectomy. The reconstruction procedure will be performed in a manner determined between the Physician and patient.

(6) Surgical Facility and Supplies

(7) Miscellaneous Hospital Charges

(a) Medically Necessary supplies and services including X-ray and laboratory charges and charges for anesthetics and administration thereof

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

(c) 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.

(d) Inpatient respiratory, physical, occupational, inhalation, speech and cardiac rehabilitation therapy

(8) Hospital Services – Outpatient

(a) Clinic services

(b) Emergency Room services

(c) Esophagogastroduodenoscopy

(d) Outpatient department

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

(f) Preadmission testing

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

(g) Student Health Centers

(h) Urgent care facility/walk-in clinic

Emergency treatment center, walk-in medical clinic or ambulatory clinic (including clinics located at a Hospital)

(9) Mental Health/Substance Use Disorders

Inpatient confinement 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.

(10) Other Services and Supplies

(a) Ambulance services:

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

When Medically Necessary, from a Hospital; or

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) Biofeedback

(d) Breast reduction surgery when deemed to be Medically Necessary

(e) 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.

(f) Chemotherapy and radiation therapy

(g) Cleft lip and cleft palate treatment is covered as described in the Schedule of Benefits including medical, dental, oral and facial surgery, surgical management and follow-up care by oral and plastic surgeons, orthodontic treatment and management, preventive and restorative dentistry to ensure good health and adequate dental structures for orthodontic treatment or prosthetic management therapy, speech therapy, audiology, and nutrition services. Dental and orthodontic treatment not related to the management of the congenital condition of the cleft lip and cleft palate is excluded.

(h) Clinical trials

Services or supplies furnished to a Covered Person enrolled in a clinical trial which are consistent with the usual and customary standard of care for an individual with the diagnosis, are consistent with the study protocol for the clinical trial and meet all the following conditions:

(i) The clinical trial is intended to treat cancer in a Covered Person who has been so diagnosed;

(ii) The clinical trial has been peer reviewed and is approved by at least one of the following:

(a) One of the United States National Institutes of Health;

(b) A cooperative group or center of the National Institutes of Health;

(c) A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants;

(d) The United States Food and Drug Administration pursuant to an investigational new drug exemption;

(e) The United States Departments of Defense or Veterans Affairs; or

(f) With respect to Phase II, III, and IV clinical trials only, a qualified institutional review board;

(iii) The facility and personnel conducting the clinical trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise;

(iv) The Covered Person meets the patient selection criteria enunciated in the study protocol for participation in the clinical trial;

(v) The Covered Person has provided informed consent for participation in the clinical trial in a manner that is consistent with current legal and ethical standards;

(vi) The available clinical or pre-clinical data provide a reasonable expectation that the Covered Person's participation in the clinical trial will provide a medical benefit that is commensurate with the risks of participation in the clinical trial;

(vii) The clinical trial does not unjustifiably duplicate existing studies; and

(viii) The clinical trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the Covered Person.

However, the coverage of services or supplies for clinical trials that are not otherwise covered under this Plan does not set any precedent or create any future liability for coverage of such services or supplies with respect to either the Covered Person who is the subject of the Plan or any other Covered Persons. Benefits provided under this section are subject to all other Plan provisions.

(i) Cochlear implants

(j) Dental/oral surgery (limited)

The following dental procedures including related Hospital expenses, (when hospital expenses are deemed to be Medically Necessary) will be covered the same as any other Illness:

(i) Treatment of an Injury to a sound natural tooth, other than from eating or chewing, or treatment of an Injury to the jaw. Surgery needed to correct Injuries to the jaw, cheek, lips, tongue, floor and roof of the mouth;

(ii) Excision of a tumor, cyst, or foreign body of the oral cavity and related anesthesia;

(iii) Biopsies of the oral cavity and related anesthesia;

(iv) Removal of bony impacted teeth, and related anesthesia; and

(v) Treatment of the temporomandibular joint.

Note: If a Covered Person has a serious medical condition that requires hospitalization or treatment in an Ambulatory Surgical Center for dental services other than those listed above, Plan benefits are payable only for the Hospital or Ambulatory Surgical Center and anesthesiologist charges, but not for the dentist's charges.

(k) Diabetes self-management training and education

Benefits limited to approved self-management education and/or training as well as professional instructions for ambulatory diabetic education

(l) Diagnostic x-ray and laboratory

X-ray, microscopic tests, laboratory tests, including electrocardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests,

or similar well-established diagnostic tests generally approved by Physicians throughout the United States

(m) Durable medical equipment

Rental or purchase (whichever is less) of durable medical equipment to aid impaired functions, including but not limited to: wheelchairs, standard hospital-type bed, mechanical respirator, bed rail, equipment for the administration of oxygen, hospital-type equipment for hemodialysis, kidney or renal dialysis (including training of a person to operate and maintain equipment), and other durable medical or surgical equipment

(n) Early Intervention Services

Early Intervention Services are covered for charges related to the treatment of conditions including, but not limited to, learning disabilities or developmental delays. Charges must be made for preventive and primary services for children. Covered services include: occupational therapy, speech therapy, physical therapy, nursing care, and psychological counseling.

(o) Elective termination of pregnancy

(p) Erectile dysfunction treatment

(q) Family planning services including consultations and diagnostic tests

(r) Genetic counseling, testing and related services

(s) Growth hormones

Growth hormones when prescribed by a board certified pediatric endocrinologist and a written treatment plan is submitted for approval to InforMed. The Covered Person must be seen by the attending Physician every six (6) months and a written response to the treatment must be verified by the Physician. The medication will be covered for a thirty (30) day supply at a time.

(t) Hearing aids and all related services as prescribed by a licensed audiologist or hearing instrument specialist are covered as described in the Schedule of Benefits including initial evaluation, fitting and adjustments, and related supplies including ear molds and batteries. The Covered Person may choose a higher priced hearing aid device and may pay the difference in cost above the maximum benefit without any financial or contractual penalty to the Covered Person or Provider.

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

(v) High tech diagnostic imaging (MRI, CT scan, PET scan)

(w) 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 expenses 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, services of any social worker, 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.

(x) Hospice care benefits are provided for Covered Persons with a life expectancy of less than six (6) months and a Hospice Plan of Care; respite services and bereavement counseling are available to members of his or her immediate family who are Covered Persons under this Plan. Benefits are limited to:

(i) Room and board for a confinement in a hospice;

(ii) Ancillary charges furnished by the hospice while the patient is confined therein, including rental of durable medical equipment which is used solely for treating an Injury or Illness;

(iii) Medical supplies, drugs and medicines prescribed by the attending Physician, but only to the extent such items are necessary for pain control and management of the terminal condition;

(iv) Physician services and/or nursing care by a registered nurse (R.N.), licensed practical nurse (L.P.N.), or a licensed vocational nurse (L.V.N.);

(v) Home health aide service;

(vi) Home care charges for home care furnished by a Hospital or home health care agency, under the direction of a hospice, including custodial care if it is provided during a regular visit by a registered nurse, a licensed practical nurse, or a home health aide;

(vii) Medical social services by licensed or trained social workers, psychologists, or counselors;

(viii) Nutrition services provided by a licensed dietitian;

(ix) Respite care for Covered Persons who are members of the hospice patient's immediate family (for the purposes of hospice benefits, the term immediate family means – parents, spouse and children); and

(x) Bereavement counseling for Covered Persons who are members of the deceased's immediate family following the death of the terminally ill Covered Person. Benefits will be payable provided:

(a) On the date immediately before his or her death, the terminally ill person was a Covered Person under the Plan under a Hospice Plan of Care and

(b) Charges for such services are incurred by the Covered Persons within six (6) months of the terminally ill Covered Person's death.

(y) Infertility treatment

Treatment of infertility including medicines and surgical procedures up to a maximum of three (3) unsuccessful cycles per Covered Person, per lifetime. However, if pregnancy occurs and results in viability through the first trimester (12 weeks), three (3) more cycles are permitted with an approved treatment plan from InforMed.

Treatment includes but is not limited to Artificial or Intrauterine Insemination (IUI), cycles for any Assisted Reproductive Technology (ART) (thaw cycles do not count toward the allowed cycles), In-Vitro Fertilization (IVF), Natural (cycle) Ovulation Retrieval in In-Vitro Fertilization (NORIF), Cryo Embryo Transfer (CET) and Freezing Embryo Transfer (FET), In-Vitro Conception (IVC), Zygote Intra-fallopian Transfer (ZIFT), Gamete Intra-fallopian Transfer (GIFT), and Intracytoplasmic Sperm Injection (ICSI)

(z) Injectable medications which must be administered in the outpatient department of a Hospital, in a Physician's office, or at home

(aa) Learning deficiencies, behavioral problems/developmental delays

(bb) Medical and enteral formulas

Special medical and enteral formulas used in the treatment of, or in association with, a demonstrable disease, condition or disorder, or to treat malabsorption. (Regular grocery products that meet the nutritional needs of the patient are not covered; e.g. over-the-counter infant formulas such as Similac and Enfamil. Specialized formulas such as Nutramigean, Alimentum, or Neocate are covered when deemed medically necessary.)

(cc) Miscellaneous medical supplies (outpatient)

Expendable supplies that are used outside of a health care setting and are available only with a physician's prescription. Covered medical supplies must be related to the use of medical equipment or devices, or are required as a result of medical or surgical treatment. Examples of covered medical supplies are colostomy bags, diabetic supplies, and supplies related to certain home care treatments.

(dd) Modified low protein foods

Food products modified to be low protein to treat inherited diseases of amino acids and organic acids. The attending Physician must issue a written order stating that the food product is needed to sustain life, and is the least restrictive and most cost-effective means for meeting the Covered Person's medical needs.

(ee) Neuromuscular stimulators including TENS units and related supplies

The Plan considers transcutaneous electrical nerve stimulators (TENS) medically necessary durable medical equipment (DME) when used as an adjunct or as an alternative to the use of drugs either in the treatment of acute post-operative pain in the first 30 days after surgery, or for certain types of chronic, intractable pain not adequately responsive to other methods of treatment including as appropriate, physical therapy, and pharmacotherapy. However, TENS is considered experimental and investigation for acute pain (less than three months duration) other than post-operative pain. TENS is also considered experimental and investigational for acute and chronic headaches, deep abdominal pain, pelvic pain, TMJ pain and all other indications because there is inadequate scientific evidence to support its efficacy for these specific types of pain.

(ff) Occupational therapy

Treatment and services rendered by a licensed occupational therapist under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility

(gg) Orthotics

Medically Necessary orthopedic braces, including leg braces with attached shoes; arm, back and neck braces; surgical supports; and head halters and specially molded orthopedic shoes and/or orthotic inserts; specially molded shoes and inserts are limited to one (1) pair per person, per calendar year.

(hh) Oxygen and other gasses and their administration

(ii) Pain management programs/clinics, including pain management injections

(jj) Physical Therapy

Medically Necessary treatment or services rendered by a licensed physical therapist under direct supervision of a Physician in a home setting or facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility

(kk) Podiatry care

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; routine services, including routine care for bunions, corns, calluses, toenails, flat feet, fallen arches, and chronic foot strain are excluded

(ll) Prosthetics

Prosthetic appliances such as artificial arms and legs including accessories; larynx prosthesis; eye prosthesis; breast prosthesis (made necessary due to Medically Necessary breast removal), and surgical brassieres (limited to two (2) per person, per calendar year) when purchased following a mastectomy. Excludes replacement, repair or adjustment, unless the replacement, repair or adjustment is necessary because of physiological changes or the prosthesis that is being replaced is at least five (5) years old and no longer serviceable.

(mm) Rehabilitation Hospital

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement and

(ii) The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement

(nn) Respiratory/pulmonary therapy

Inhalation therapy under the direct supervision of a Physician in a home setting or a facility whose primary purpose is to provide medical care for an Illness or Injury, or in a freestanding duly licensed outpatient therapy facility

(oo) Skilled Nursing Facility

Inpatient confinement in a Skilled Nursing Facility and/or in a Rehabilitation Hospital if:

(i) Charges are incurred within fourteen (14) days following a Hospital confinement and

(ii) The attending Physician certifies that twenty-four (24) hour nursing care is Medically Necessary for recuperation from the Illness or Injury which required the Hospital confinement

(pp) Sleep disorders

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

(qq) Smoking cessation clinics and programs

(rr) Speech Therapy

Services of a legally qualified speech therapist under the direct supervision of a Physician for restorative or rehabilitative speech therapy for speech loss or impairment, or due to surgery performed on account of an Illness or Injury. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

(ss) Temporomandibular joint disorders treatment, excluding devices or orthodontia

(tt) Voluntary sterilization

(uu) Wigs

Wigs for hair loss resulting from chemotherapy, radiation therapy, infections, burns, traumatic injury, congenital baldness, or medical conditions resulting in alopecia areata or alopecia totalis (capitus). No benefits are provided for wigs when hair loss is due to: male pattern baldness; female pattern baldness; or natural or premature aging.

(11) Wellness Benefits

(a) Childbirth classes

Full reimbursement will be made for a childbirth class completed by a pregnant Covered Person upon filing a claim form with a receipt which shows full payment. No reimbursement will be made unless the course is completed, unless the delivery occurs before the course ends.

(b) Fitness reimbursement benefit

Reimbursement will be made for health club membership fees up to a total reimbursement of $150 per family, per calendar year. Membership fees must be paid in the current calendar year for membership in that year, and the paid date must be within the Covered Person's dates of enrollment in this Plan. Health club membership must be to a qualified, full-service health and fitness club with cardiovascular and strength-training equipment and facilities for exercising and improving physical fitness for at least four (4) consecutive months and have been on this plan for at least four (4) consecutive months to be eligible for reimbursement.

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

The following are excluded from Covered Expenses and no benefits shall be paid for:

(1) Expenses incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.

(2) Claims submitted more than one (1) year after the Expense Incurred Date, unless the claim was delayed due to a Covered Person's legal incapacitation.

(3) Amounts in excess of the fee schedule amount for Tier 1 or Tier 2 Providers, or, in excess of the Reasonable and Customary Charges or the HPHC fee schedule, whichever applies, for Tier 3 Providers.

(4) Services or supplies 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.

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

(6) 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.

(7) Treatment which is not the result of an Injury or Illness, except for benefits specifically stated as covered under the Plan.

(8) 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.

(9) 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.

(10) 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.

(11) 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.

(12) 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.

(13) 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.

(14) 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.

(15) Costs associated with broken appointments.

(16) Court-ordered treatment or any treatment not initiated by a Physician or covered provider of any kind.

(17) Treatment, services or supplies provided by a member of the Covered Person's immediate family, any 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.

(18) Abortifacient drugs

(19) Acupuncture therapy

(20) Chelation therapy

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

(22) 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."

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

(24) Fluoride for Covered Persons age 5 and over

(25) Food supplements, except for benefits specifically stated as covered

(26) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, massage therapy, aromatherapy and alternative medicine, except for benefits specifically stated as covered under this Plan.

(27) Immunizations required for travel.

(28) Lenses, frames, and contact lenses

(29) Marital counseling

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

(31) Methadone maintenance and treatment

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

(33) "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.

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

(35) 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.

(36) Planned home births.

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

(38) Private duty nursing

(39) Sex therapy or transsexual surgery and related preoperative and postoperative procedures or complications, which, as their objective, change the person's sex.

(40) Surrogate parenting, any expenses related to the use of a gestational carrier.

(41) Visual refraction surgery, including radial keratotomy.

(42) Vitamins, except for benefits specifically stated as covered under this Plan.

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility

Benefit eligible Employees, and their Eligible Dependents, are initially eligible to participate in the Plan on the Employee's first day of continuous employment (actively at work). For the purposes of this Plan, "benefit eligible employee" means an Employee of Southcoast Hospital Group, Southcoast Physician Group or Southcoast Visiting Nurse Association regularly scheduled to work at least 20 control hours per week for those Employees hired prior to January 1, 2011, and regularly scheduled to work at least 24 control hours per week for Employees hired January 1, 2011 or later or as stated in your collective bargaining agreement.

Pre-Age 65 Retirees who are former Employees between ages 60 and 65, 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 at least 20 years after reaching age 40, and who retired before reaching age 65 are eligible to participate in the Plan upon retirement.

B. Enrollment

(1) Enrollment for Employees and their Eligible Dependents

To enroll in this Plan, an Employee must elect coverage during an applicable enrollment period shown in the chart below. To make an election, all the required enrollment forms must be submitted to the Plan Administrator by the specified deadlines, unless due to administrative error.

In general, an Employee's election to enroll (or not enroll) for coverage under this Plan for the Employee and/or Eligible Dependents is irrevocable for the duration of the Plan Year for which the election is made.

In certain limited circumstances, however, Employees may be eligible to change their elections to enroll for, cancel or change coverage for themselves and/or their Eligible Dependents during the Plan Year, provided that the required election/enrollment forms are submitted by the specified deadline.

The following chart summarizes the times when an Employee may enroll or change a current election under this Plan and the applicable enrollment/election deadlines. The requirements for making elections during each period are detailed in the chart below.

Enrollment Periods

Enrollment/election due to:	Enrollment/election deadline:
1. Initial Eligibility Period	Thirty (30) days from the date of benefit eligibility
2. Open Enrollment Period	The last day of the annual enrollment period specified by the Plan Administrator
3. Qualified Change in Status	Thirty (30) days after the date of the Qualifying Change in Status
4. Special Enrollment Period following a gain or loss of eligibility for Medicaid or CHIP	Sixty (60) days after the date of the loss or gain of eligibility for Medicaid or CHIP
5. Special Enrollment Period following loss of other coverage	Thirty (30) days after the date of the loss of other coverage

(a) **Initial Eligibility Period**

An Employee may elect to enroll in this Plan during the 30-day period following the Employee's benefit eligibility by submitting all required forms to the Plan Administrator. Any election made to enroll or not to enroll during the initial eligibility period will be irrevocable for the duration of the Plan Year, unless the Employee becomes eligible to change an election during the enrollment periods described under (c), (d), or (e) below. For subsequent Plan Years, an Employee may change the election during the Open Enrollment Period.

(b) **Open Enrollment Period**

Once a year, during the Open Enrollment Period held on dates determined by the Plan Administrator, an Employee may change his or her election(s) with respect to enrollment in this Plan for himself and/or his Eligible Dependents.

In the absence of an affirmative election during the Open Enrollment Period, an Employee's election with respect to his or her medical and prescription drug benefits under this Plan which is in effect as of the last day of the Plan Year will automatically carry over for the following Plan Year.

(c) **Qualified Change in Status**

An Employee may change election with regard to coverage under this Plan after the initial eligibility period and outside the Open Enrollment Period following a Qualified Change of Status as permitted under the Internal Revenue Code of 1986, as amended. The Qualified Changes of Status that are applicable under this Plan include:

- Marriage, legal separation, annulment, establishment or dissolution of domestic partnership, or divorce of the Employee;
- Birth, adoption or placement for adoption, or change in custody of the Employee's child;
- Death of the Employee's spouse, domestic partner or other Eligible Dependent;
- A child's loss or gain of Eligible Dependent status;
- An Employee's, domestic partner's or spouse's commencement of or return from an unpaid leave of absence;
- A significant change in the cost or coverage of the Employee's domestic partner's or spouse's employer-provided health care coverage;
- A spouse's or domestic partner's employer's open enrollment period during which the spouse or domestic partner changes his or her election regarding health care coverage;
- A change from part-time to full-time employment, or from full-time to part time employment, for the Employee, domestic partner or spouse;
- A spouse, domestic partner or other Eligible Dependent becomes employed or unemployed; and
- Other Qualified Changes in Status as may be permitted under the Internal Revenue Code of 1986, as amended.

A change to an election under this section may be to enroll for coverage, terminate coverage or change coverage level under this Plan, provided the election change is consistent with the Qualified Change of Status. For example, an Employee who gets married may elect to drop coverage under this Plan to enroll in his or her new spouse's plan or may elect to add the new spouse and/or stepchildren to this Plan.

To make an election change under this section, the Employee must submit a completed enrollment form to the Plan Administrator, with documentation of the Qualified Change of Status, within thirty (30) days of such change.

(d) **Special Medicaid/CHIP Enrollment Periods**

If an Employee is not covered under this Plan, or is covered but has not enrolled his Eligible Dependents, he may enroll for himself and/or his Eligible Dependents if:

(i) The Employee's or an Eligible Dependent's coverage under Medicaid or CHIP is terminated as a result of loss of eligibility under such programs, or the Employee or Eligible Dependent becomes newly eligible for premium subsidy through Medicaid or CHIP to help pay the cost of coverage under this Plan; and

(ii) The Employee submits a completed enrollment form to the Plan Administrator, with documentation of the loss of Medicaid or CHIP coverage, or of new eligibility for Medicaid or CHIP premium subsidy, within sixty (60) days of the date of the applicable loss of coverage or new eligibility for the premium subsidy.

(e) **Special Enrollment Period Following Involuntary Loss of Other Coverage**

An Employee who is not participating in the Plan, but meets the eligibility requirements, may elect to enroll himself and his Eligible Dependents if all the conditions below are met:

(i) The Employee declined coverage under the Plan for himself and his Eligible Dependents when it was offered previously.

(ii) The alternative health coverage was involuntarily lost because:

- It was COBRA continuation coverage that has been exhausted;
- Eligibility for the alternative coverage was lost (for reasons other than the Employee's voluntary cancellation of the coverage, failure to pay premiums or for cause);
- All benefits under the alternative coverage have been exhausted under its lifetime benefit limits; or
- Employer contributions toward the cost of the alternative coverage terminated.

(iii) The Employee submits a completed enrollment form to the Plan Administrator, with written documentation that confirms the involuntary loss of alternative coverage, within thirty (30) days after the date on which the alternative coverage was involuntarily lost.

(2) Enrollment for Pre-Age 65 Retirees

An active Employee who is covered under the Plan, retires prior to age 65, and otherwise meets the criteria as a Pre-Age 65 Retiree remains eligible for coverage under the Plan after retirement until age 65. See Human Resources to initiate enrollment.

C. Participation

(1) Participation for Employees and their Eligible Dependents

The chart below provides an overview of when participation begins or ends based on a permitted election provided all enrollment materials are submitted by the deadlines shown under Section B. *Enrollment*. Coverage and participation under this Plan begin and end on the same date.

When Participation Begins/Ends

Election during	Participation for Employee	Participation for Eligible Dependents enrolled by Employee
1. Initial Eligibility Period	Begins on ▪ The initial eligibility date	Begins on: ▪ The date the Employee's coverage begins
2. Open Enrollment Period	Begins or ends, as applicable, on the first day of the first Plan Year following the end of the Open Enrollment Period	
3. Enrollment Period following Qualified Change in Status	Begins or ends on the date of the Qualified Change of Status	
4. Special Medicaid/CHIP Enrollment Period	Begins or ends, as applicable, on the date of the loss or gain of eligibility for Medicaid or CHIP	
5. Special Enrollment Period: Loss of eligibility for other coverage	Begins on date of loss of coverage	

(a) Participation during Periods of Disability, Layoff or Leave of Absence

(i) Non-FMLA Leave of Absence

Employees may continue to participate in the Plan for up to a combined maximum of one (1) year while on approved leaves of absence as described below unless otherwise required by law. After the accumulation of one (1) year of any combination of approved leaves of absence over the course of an employee's tenure, coverage will be terminated and continuation of coverage under COBRA will be offered.

(a) Disability Leave of Absence

An Employee who is absent from work and who is Totally Disabled as defined under this Plan, (other than under FMLA) may continue to participate in this Plan for a period of up to one (1) year, less any previous period of participation in the Plan while on leave, and subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after one (1) year or one (1) year of participation in the Plan while on

current or previous periods of leave, or does not continue the necessary contributions, eligibility in the Plan will be terminated and continuation of coverage under COBRA will be offered.

(b) **Medical Leave of Absence**

A Employee who is absent from work on a full-time basis due to an approved medical leave of absence and who is not engaged in any other occupation for compensation, profit or gain, may continue to participate in this Plan for a period of up to one (1) year, less any previous period of participation in the Plan while on leave, and subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after the earlier of one (1) year or one (1) year of participation in the Plan while on current or previous periods of leave, or does not continue the necessary contributions, eligibility in the Plan will be terminated and continuation of coverage under COBRA will be offered.

(ii) **Leave of Absence under FMLA**

An Employee who is entitled to and takes a family or medical leave under the terms of the FMLA (Family and Medical Leave Act of 1993, as amended), and the Employee's covered Eligible Dependents, may continue to participate in this Plan during the FMLA leave until the earlier of the expiration of the leave or the date the Employee gives notice to the Employer that the Employee does not intend to return to work at the end of the FMLA leave. If participation is maintained during the leave, the Employee must continue to make any required contributions.

If the Employee chooses not to participate while on an FMLA leave, but subsequently returns to Actively at Work status upon or before the expiration of the leave, the Employee and all Eligible Dependents who were covered under the Plan when the leave began shall immediately become covered under the Plan.

The Employer's obligation to provide ongoing coverage under this Plan for an Employee on FMLA ceases if the Employee is more than thirty (30) days late making a required minimum payment.

Note: Periods of participation during non-FMLA leaves of absence, as described above, do not accumulate toward FMLA leaves of absence. However, periods of participation during FMLA leaves of absence do accumulation toward the one (1) year maximum period of participations in the Plan while on leave this is applicable

to any combination of approved leaves of absence over the course of an employee's tenure as described above.

(b) **Participation for Employees under Compensation Maintenance Agreements and/or Severance Agreements**

Employees and/or their spouses who enter into special written arrangements with the Employer are eligible to continue participation in the Plan following termination of the Employee's employment as specified under the terms of each individual's arrangement. In each such case, coverage following the Employee's termination of employment is offered under the terms of COBRA for the first 18 months, and continues as applicable, following expiration of the former Employee's and/or their spouse's eligibility for COBRA coverage for the period specified under the terms of each individual's arrangement.

(c) **Participation in Cases of Reemployment**

(i) Participation in the Plan will begin immediately for any Covered Person who discontinued coverage during a leave of absence taken under the FMLA, disability leave (other than under FMLA), or medical leave of absence (other than under FMLA) by the Employee, provided the Employee returns to Actively at Work status before or immediately following the expiration of the FMLA leave, disability leave (other than under FMLA), or medical leave of absence (other than under FMLA).

(ii) Participation in the Plan will begin immediately for any former enrolled Employee and his or her Eligible Dependents who have continuously been covered under this Plan through COBRA continuation coverage where the Employee regains eligibility for coverage under the Plan on the basis of full-time employment while such continuation coverage is in effect.

(iii) Participation in the Plan will begin immediately for an Employee absent from work due to military service on the first day the Employee returns to Actively at Work status, whether or not an Employee elects COBRA continuation coverage under the Uniformed Services Employment and Reemployment Rights Act (USERRA), provided the Employee returns to Actively at Work status:

(a) On the first full business day following completion of the military service for a leave of thirty (30) days or less; or

(b) Within fourteen (14) days of completing military service for a leave of thirty-one (31) to one hundred eighty (180) days; or

(c) Within ninety (90) days of completing military service for a leave of more than one hundred eighty (180) days

In each case, a reasonable amount of travel time or recovery time for an Illness or Injury determined by the Veterans' Administration to be service connected will be allowed.

When participation in this Plan is reinstated, all provisions and limitations in this Plan will apply to the extent that they would have applied if the military leave had not been taken and coverage had been continuous under this Plan. The eligibility waiting period will be waived as if the Employee had been continuously covered under this Plan from the original effective date.

(iv) In each other case of reemployment or transfer to benefit eligible status from non-benefit eligible status, the Covered Person will become covered upon the Employee's return to Actively at Work full-time status in accordance with the provisions of Section A of this Article (relating to initial eligibility following commencement of employment).

(2) Participation for Pre-Age 65 Retirees

Participation for a Pre-Age 65 Retiree begins upon retirement for an active Employee who, immediately prior to retirement, is covered under the Plan and initiates post-retirement coverage as a Pre-Age 65 Retiree by contacting Human Resources and otherwise meets the criteria for a Pre-Age 65 Retiree.

VIII. COORDINATION OF BENEFITS

A. 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:

(a) 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.

(b) Charges related to retail or mail-order prescription drug claims which are administered by the Prescription Drug Manager for this Plan.

B. 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.

C. Determining Order of Payment

If a Covered Person is covered under two or more health Plans, the order in which benefits are paid will be determined is as follows:

(1) The Plan covering the Covered Person other than as an Eligible Dependent, for example as an Employee, member, subscriber, policyholder or Pre-Age 65 Retiree pays benefits first. The Plan covering the Covered Person as an Eligible Dependent pays benefits second.

(2) If no Plan is determined to have primary benefit payment responsibility under (1), then the Plan that has covered the Covered Person for the longest period has the primary responsibility.

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

(4) The Plan covering the parent of the Eligible Dependent child pays first if the parent's birthday (month and day of birth, not year) falls earlier in the year. The Plan covering the parent of an Eligible Dependent child pays second if the parent's birthday falls later in the year.

(5) In the event that the parents of the Eligible Dependent child are divorced or separated, the following order of benefit determination applies:

(a) The Plan covering the parent with custody pays benefits first;

(b) If the parent with custody has not remarried, then the Plan covering the parent without custody pays benefits second;

(c) If the parent with custody has remarried, then the Plan covering the step-parent pays benefits second and the Plan covering the parent without custody pays benefits third; and

(d) If a divorce decree or other order of a court of competent jurisdiction places the financial responsibility for the child's health care expenses on one of the parents, then the Plan covering that parent pays benefits first.

(6) The Plan covering the Covered Person as an Employee (or as that Employee's Eligible Dependent) pays benefits first unless the Employee is laid-off or retired. The Plan covering the Covered Person as a laid-off or retired Employee (or as a laid-off or retired Employee's Eligible Dependent) pays benefits second.

(7) The Plan covering a Covered Person as an Employee or Pre-Age 65 Retiree (or as an Eligible Dependent of the Employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under another Plan, and such Other Plan pays benefits second for such an individual. Conversely, this Plan pays secondary benefits for any Employee who is provided COBRA continuation under this Plan and who also is covered simultaneously under another Plan as an

Employee (or as an Eligible Dependent of an Employee). In the event of conflicting coordination provisions between this Plan and any Other Plan, this Plan will pay primary benefits for an individual only if this Plan has provided coverage for a longer period of time.

D. 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.

E. Persons Covered by Medicare

A Covered Person who becomes entitled to medical benefit coverage under Medicare shall remain eligible for benefits under this Plan on the same terms and conditions as any other Covered Person. This Plan will coordinate benefits with Medicare in accordance with the rules of the Medicare Secondary Payor (MSP) Program as promulgated by the Centers for Medicare & Medicaid Services (CMS) as may be amended from time to time. The Medicare secondary payor rules under Social Security Act Section 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. These rules will determine when this Plan will be the primary payer of covered Medical benefit expenses and when Medicare will be the primary payer.

In the event that the Plan would otherwise be allowed (as in accordance with the Medicare secondary payor rules) to be a secondary payor of covered medical expense benefits for 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, the Covered Person's benefits under this Plan will be determined on an assumptive basis, whereby benefits will be calculated as if Medicare provided reimbursement for the expenses being claimed.

F. Discrimination Against Older Participants Prohibited

This Plan will provide benefits for any Covered Person age 65 or older under the same terms and conditions that apply to a Covered Person who is under age 65.

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

In enrolling an Employee or Pre-Age 65 Retiree as a Covered Person or in determining or making any payments for benefits of an Employee or Pre-Age 65 Retiree as a Covered Person, the fact that the Employee or Pre-Age 65 Retiree 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.

H. Plan Charges Covered by Medicaid or CHIP (Children's Health Insurance Plan)

This Plan will not reduce or deny benefits for any Covered Person to reflect the fact that such a Covered Person is eligible to receive medical assistance through Medicaid or CHIP.

I. 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.

J. 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.

K. 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.

L. 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 Employee, Eligible Dependent or Pre-Age 65 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 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. Fiduciary Liability

To the extent permitted by law, neither the Plan Administrator nor any other person will incur any liability for any acts or for failure to act.

F. 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.

G. 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.

H. 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.

I. 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 AND CONTINUATION OF COVERAGE

A. Termination of Coverage

(1) Termination Events for Employees and Eligible Dependents

The participation in and coverage under this Plan of any Employee and Eligible Dependent terminates on the earliest of:

(a) The day the Employee terminates employment.

(b) The day the Employee ceases to be in a class of eligible Employees.

(c) The day the Employee fails to return to Actively at Work status following expiration of an approved leave of absence.

(d) The day the Employer terminates the Employee's coverage.

(e) The day this Plan terminates.

(f) The day the Employee dies.

(g) When an Employee enters service in the Uniformed Services on an active duty basis coverage will be terminated and COBRA will be offered or coverage may be extended as stated by the Employer at the time the Covered Person is called into active duty.

(h) The last day of the period for which the Employee fails to make any required contributions.

(2) Earlier Termination of Eligible Dependent Coverage

The coverage of any Eligible Dependent will terminate before the termination of the Employee's coverage on the earlier of (i) the date that the dependent no longer satisfies the definition of an Eligible Dependent or (ii) the last day of the period in which the Employee fails to make any required contribution for Eligible Dependent coverage.

(3) Termination Events for Pre-Age 65 Retirees

The participation in and coverage under this Plan of any Pre-Age 65 Retiree terminates on the earliest of:

(a) The day the Pre-Age 65 Retiree reaches age 65.

(b) The day the Pre-Age 65 Retiree ceases to be in a class of eligible Pre-Age 65 Retirees.

(c) The day the Employer terminates the Pre-Age 65 Retiree's coverage.

(d) The day this Plan terminates.

(e) The day the Pre-Age 65 Retiree dies.

(f) The first day of the period for which the Pre-Age 65 Retiree fails to make any required contributions, if applicable.

(4) 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 or your dependent's 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, 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 you will have the right to appeal the Plan's termination of coverage.

B. Certificate of Coverage

As mandated by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan will provide a Certificate of Coverage to any Covered Person after the Covered Person loses coverage under the Plan. In addition, a Certificate will be provided upon request, if the request is made within twenty-four (24) months after the Covered Person loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish the same. To request a Certificate of Creditable Coverage from the Plan, contact Southcoast Health Plan customer service, 1500 West Park Drive, Suite 330, Westborough, MA 01581, (877) 234-5550.

The Certificate of Creditable Coverage will document the coverage for the Covered Person(s), including:

(1) The name of the Plan;

(2) The date of the Certificate;

(3) A statement if the Covered Person has at least twelve (12) months or in the case of a Late Enrollee, eighteen (18) months of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage, or the date any Waiting Period (and affiliation period, if applicable) began;

(4) The date Creditable Coverage began;

(5) The date Creditable Coverage ended;

(6) The Plan Administrator; and

(7) Contact information for the Plan.

C. COBRA (Consolidated Omnibus Budget Reconciliation Act, as amended)

During any Plan Year during which the Employer has more than 20 Employees (as defined under COBRA for this purpose), each person who is a Qualified Beneficiary (as defined below) has the right to elect to continue coverage under this Plan upon the occurrence of a Qualifying Event (as defined below) that would otherwise result in a loss of coverage under the Plan. Extended coverage under the Plan is known as "COBRA continuation coverage."

COBRA continuation coverage is group health insurance coverage that an employer must offer to certain Plan participants and their eligible family members (called "Qualified Beneficiaries") at group rates for up to a statutory-mandated maximum period of time or until they become ineligible for COBRA continuation coverage, whichever occurs first. The right to COBRA continuation coverage is triggered by the occurrence of certain events that result in the loss of coverage under the terms of the employer's Plan (the "Qualifying Event"). The coverage will be identical to the Plan coverage that the Qualified Beneficiary had immediately before the Qualifying Event, or if the coverage has been changed, the coverage will be identical to the coverage provided to similarly situated active Employees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

(1) Qualified Beneficiaries

In general, a Qualified Beneficiary is:

(a) Any Employee who, on the day before a Qualifying Event, is covered under the Plan, or the spouse of a covered Employee or an Eligible Dependent child of a covered Employee*. If, however, an Employee is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Employee will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Employee experiences a Qualifying Event.

(b) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage. If, however, an Employee is denied or not offered coverage under the Plan under circumstances in which the denial or failure to offer constitutes a violation of applicable law, then the Employee will be considered to have had the Plan coverage and will be considered a Qualified Beneficiary if that Employee experiences a Qualifying Event.

* A Qualified Beneficiary will also include any Eligible Dependent as defined in the General Definitions section under this Plan who is a same-sex spouse, domestic partner, or child of a same-sex spouse or domestic partner.

The term “covered Employee” includes not only common-law Employees (whether part-time or full-time) but also any Employee who is provided coverage under the Plan due to his or her performance of services for the employer sponsoring the Plan (e.g., self-employed Employees, independent contractor, or corporate director).

An Employee is not a Qualified Beneficiary if the Employee's status as a covered Employee is attributable to a period in which the Employee was a nonresident alien who received no earned income from the employer that constituted income from sources within the United States. Nor are such Employee’s spouse or Eligible Dependent children Qualified Beneficiaries.

Each Qualified Beneficiary (including a child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage) must be offered the opportunity to make an independent election to receive COBRA continuation coverage.

(2) Qualifying Events

A Qualifying Event is any of the following if the Plan provides that the Qualified Beneficiary would lose coverage (i.e., cease to be covered under the same terms and conditions as in effect immediately before the Qualifying Event) in the absence of COBRA continuation coverage:

(a) The death of a covered Employee.

(b) The termination (other than by reason of the Employee’s gross misconduct), or reduction of hours, of a covered Employee’s employment.

(c) The divorce or legal separation or termination of domestic partnership of a covered Employee from the Employee’s spouse.

(d) A covered Employee’s entitlement to Medicare.

(e) An Eligible Dependent child’s ceasing to satisfy the Plan’s definition of an Eligible Dependent child (e.g., attainment of the maximum age for dependency under the Plan).

(f) A proceeding in bankruptcy under Title 11 of the U.S. Code with respect to an Employer from whose employment a covered Employee retired at any time.

If the Qualifying Event causes the covered Employee, or the spouse or an Eligible Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event (or in the case of the bankruptcy of the Employer, any substantial elimination of coverage under the Plan occurring within 12 months

before or after the date the bankruptcy proceeding commences), the persons losing such coverage become Qualified Beneficiaries under COBRA if all the other conditions of the COBRA law are also met.

The taking of leave under the FMLA does not constitute a Qualifying Event. A Qualifying Event occurs, however, if an Employee does not return to employment at the end of the FMLA leave and all other COBRA continuation coverage conditions are present. If a Qualifying Event occurs, it occurs on the last day of FMLA leave and the applicable maximum coverage period is measured from this date (unless coverage is lost at a later date and the Plan provides for the extension of the required periods, in which case the maximum coverage date is measured from the date when the coverage is lost.) Note that the covered Employee and family members will be entitled to COBRA continuation coverage even if they failed to pay the Employee portion of premiums for coverage under the Plan during the FMLA leave.

(3) Election Periods

To be eligible for COBRA coverage, a Qualified Beneficiary must make a timely election. An election is timely if it is made during the election period. The election period begins no later than the date the Qualified Beneficiary loses coverage on account of the Qualifying Event and ends 60 days after the later of the date the Qualified Beneficiary loses coverage on account of the Qualifying Event or the date the Qualified Beneficiary is notified of the right to elect COBRA continuation coverage.

(4) Informing the Plan Administrator of the occurrence of a Qualifying Event

In general, the Employer or Plan Administrator must determine when a Qualifying Event has occurred. However, each covered Employee or Qualified Beneficiary is responsible for notifying the Plan Administrator of the occurrence of a Qualifying Event that is:

(a) An Eligible Dependent child ceasing to be an Eligible Dependent child under the generally applicable requirements of the Plan.

(b) The divorce or legal separation or termination of domestic partnership of the covered Employee.

The Plan is not required to offer the Qualified Beneficiary an opportunity to elect COBRA continuation coverage if the notice is not provided to the Plan Administrator within 60 days after the later of: the date of the Qualifying Event or the date the Qualified Beneficiary would lose coverage on account of the Qualifying Event.

(5) Revoking a Waiver of Coverage during the Election Period

If a Qualified Beneficiary waives COBRA continuation coverage during the election period, the waiver can be revoked at any time before the end of the election period. Revocation of the waiver is an election of COBRA continuation coverage. When a waiver is revoked, coverage begins from the date of the waiver, not from the date of the loss of coverage. Waivers and revocations of waivers are considered made on the date they are sent to the Employer or Plan Administrator, as applicable.

(6) Termination of COBRA Continuation Coverage

Except for an interruption of coverage in connection with revocation of a waiver as described above, COBRA continuation coverage that has been elected for a Qualified Beneficiary must extend for at least the period beginning on the date of the Qualifying Event and ending not before the earliest of the following dates:

(a) The last day of the applicable maximum COBRA coverage period.

(b) The first day for which Timely Payment as defined below is not made to the Plan with respect to the Qualified Beneficiary.

(c) The date upon which the Employer ceases to provide any group health plan (including successor plans) to any Employee.

(d) The date, after the date of the election, that the Qualified Beneficiary first becomes covered under any other Plan that does not contain any exclusion or limitation with respect to any pre-existing condition, other than such an exclusion or limitation that does not apply to, or is satisfied by, the Qualified Beneficiary.

(e) The date, after the date of the election, that the Qualified Beneficiary is entitled to Medicare benefits (either part A or part B, whichever occurs earlier).

(f) In the case of a Qualified Beneficiary entitled to a disability extension as described below, the later of:

(i) 29 months after the date of the Qualifying Event, or (ii) the first day of the month that is more than 30 days after the date of a final determination under Title II or XVI of the Social Security Act that the disabled Qualified Beneficiary whose disability resulted in the Qualified Beneficiary's entitlement to the disability extension is no longer disabled, whichever is earlier; or

(ii) The end of the maximum coverage period that applies to the Qualified Beneficiary without regard to the disability extension.

In the case of an Employee who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Employee's relationship to a Qualified Beneficiary, if the Plan's obligation to make COBRA continuation coverage available to the Qualified Beneficiary ceases, the Plan is not obligated to make coverage available to the Employee who is not a Qualified Beneficiary.

(7) Maximum COBRA coverage periods

The maximum coverage periods are based on the type of the Qualifying Event and the status of the Qualified Beneficiary, as shown below.

(a) In the case of a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period ends 18 months after the Qualifying Event if there is no disability extension and 29 months after the Qualifying Event if there is a disability extension.

(b) In the case of a covered Employee's entitlement in the Medicare program before experiencing a Qualifying Event that is a termination of employment or reduction of hours of employment, the maximum coverage period for Qualified Beneficiaries other than the covered Employee ends on the later of:

(i) 36 months after the date the covered Employee becomes enrolled in the Medicare program; or

(ii) 18 months (or 29 months, if there is a disability extension) after the date of the covered Employee's termination of employment or reduction of hours of employment.

(c) In the case of a bankruptcy Qualifying Event, the maximum coverage period for a Qualified Beneficiary who is the retired covered Employee ends on the date of the retired covered Employee's death.

(d) In the case of a Qualified Beneficiary who is a child born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage, the maximum coverage period is the maximum coverage period applicable to the Qualifying Event giving rise to the period of COBRA continuation coverage during which the child was born or placed for adoption.

(e) In the case of any Qualifying Event other than that described above, the maximum coverage period ends 36 months after the Qualifying Event.

(8) Limited circumstances under which the maximum coverage period can be expanded

If there is a second Qualifying Event during the 18 months of COBRA continuation coverage, the Employee's spouse, surviving spouse or Eligible Dependent children can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second Qualifying Event is properly given to the Plan Administrator. This extension is available if the Employee or former Employee dies, or gets divorced or legally separated, or if the Employee or former Employee's domestic partnership is terminated or if the Eligible Dependent child is no longer eligible under the Plan as an Eligible Dependent child. However, the extension is available only if the event would have caused the spouse or Eligible Dependent children to lose coverage under the Plan had the first Qualifying Event not occurred. In all of these cases, the Qualified Beneficiary must notify the Plan Administrator of the second Qualifying Event with 60 days of the Qualifying Event.

(9) Disability Extensions of Coverage

A disability extension will be granted in connection with the Qualifying Event that is a termination or reduction of hours of a covered Employee's employment, if a Qualified Beneficiary (whether or not a covered Employee) is determined under Title II or XVI of the Social Security Act to have been disabled at some time before the 60th day of COBRA continuation coverage. The disability must last at least until the end of the 18-month period of continuation coverage. To qualify for the disability extension, the Qualified Beneficiary must also provide the Plan Administrator with notice of the disability determination on a date that is both within 60 days after the date of the determination and before the end of the original 18-month maximum coverage period.

(10) Payment for COBRA Coverage

The cost for any period of COBRA continuation coverage is 102% of the applicable premium for active employees. The Plan may require payment of 150% of the applicable premium for any period of COBRA continuation coverage based on a disability extension. The Plan will terminate a Qualified Beneficiary's COBRA continuation coverage as of the first day of any period for which timely payment is not made to the Plan with respect to that Qualified Beneficiary.

Payments for COBRA continuation coverage may be made in monthly installments or may be made for multiple months in advance.

(11) Timely Payment for COBRA Coverage

Timely Payment for a period of coverage means payment that is made to the Plan by 30 days after the first day of the applicable coverage period. Notwithstanding the above, a Qualified Beneficiary has 45 days after the date the election of COBRA continuation coverage to make the initial payment for coverage. The

initial payment for coverage must include payment for the entire period that begins on the date of the Qualifying Event (or revocation of waiver) and ends on the last day of the month in which the initial payment is submitted. Payment is considered made on the date on which it is sent to the Plan.

(12) Certificates of Coverage

The Plan will provide Covered Persons with an automatic Certificate of Coverage in cases where they lose coverage under this Plan and are entitled to elect Continuation Coverage. Such Certificates will be provided at the following times:

(a) For an Employee who is a Qualified Beneficiary entitled to elect Continuation Coverage, no later than when a notice is required to be provided for a Qualifying Event.

(b) For a Covered Person who is not a Qualified Beneficiary entitled to elect Continuation Coverage, within a reasonable time after coverage ceases.

(c) For a Covered Person who is a Qualified Beneficiary and who has elected Continuation Coverage, within a reasonable time after cessation of Continuation Coverage or, if applicable, after the expiration of any grace period for the payment of premiums.

(13) COBRA Coverage for Employees in the Uniformed Services

For purposes of this Article X, an Employee who is absent from work for more than 31 days in order to fulfill a period of duty in the Uniformed Services will experience a Qualifying Event as of the first day of the Employee's absence for such duty. Such an Employee and any of the Employee's covered Eligible Dependents will be treated as any other Qualified Beneficiary under Section C for all purposes of COBRA. However, to the extent that the Uniformed Services Employment and Reemployment Rights Act ("USERRA") provides greater continuing coverage rights, the provisions of USERRA will apply. The Plan Administrator will furnish the Employee and the Employee's covered Eligible Dependents a notice of the right to elect COBRA continuation coverage (as provided above) and shall afford the Employee the opportunity to elect such coverage. However, the maximum period of coverage available to the Employee and the Employee's Eligible Dependents under USERRA is the lesser of (a) 24 months beginning on the date of the Employee's absence or (b) the day after the date on which the Employee fails to apply for or return to active employment from active duty under USERRA with the Employer. If the leave is thirty (30) days or less, the contribution rate will be the same as for active Employees. If the leave is longer than thirty (30) days, the Employee is responsible for the required contribution, if applicable, not to exceed 102% of the cost 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.

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:

- Director of Compensation and Benefits
- Medical Director
- Human Resources Consultant
- Senior Vice President of Human Resources
- Vice President of Human Resources
- Senior Benefits Analyst
- Senior Human Resources Consultant
- Human Resources Director
- Employees and other workforce members at the direction of the above listed classes of employees
- Human Resources Director Secretary
- Benefits Specialist
- Human Resources Receptionist
- Human Resources Coordinator
- 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;

- Apply reasonable and appropriate security measures to maintain adequate separation between the Plan and itself.

XII. 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 or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").

(2) Covered Person, 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. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person 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 agrees to include the Plan's name as a co-payee on any and all settlement drafts.

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

B. Subrogation

(1) As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to subrogate the Plan to 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 is entitled, regardless of how classified or characterized.

(2) If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the illness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

(3) The Plan may in its own name or in the name of the Covered Person 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 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 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 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 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 subrogation lien. The obligation 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.

(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, 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.

(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. 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.

E. Separation of Funds

Benefits paid by the Plan, funds recovered by the Covered Person, and funds held in trust over which the Plan has an equitable lien exist separately from the property and estate of the Covered Person, such that the death of the Covered Person, or filing of bankruptcy by the Covered Person, 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.

F. Wrongful Death

In the event that the Covered Person 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.

G. 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; and

(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.

(2) If the Covered Person 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 or condition, out of any proceeds, judgment or settlement received, the Covered Person 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.

(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.

H. Offset

Failure by the Covered Person and/or his or her attorney to comply with any of these requirements may, at the Plan's discretion, result in a forfeiture of payment by the Plan of medical benefits and any funds or payments due under this Plan may be withheld until the Covered Person satisfies his or her obligation.

I. Minor Status

(1) In the event the Covered Person 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.

J. 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.

K. 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 Employees or Pre-Age 65 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 an Employee or Pre-Age 65 Retiree or any other person. Neither an Employee or Pre-Age 65 Retiree nor a beneficiary of an Employee or Pre-Age 65 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, nor shall it be consideration or an inducement for the initial or continued employment of any Employee. Likewise, maintenance of this Plan shall not be construed to give any Employee the right to be retained as an Employee by the Employer or 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 Employee or eligible Beneficiary or Pre-Age 65 Retiree 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 Employee, Eligible Dependent or Pre-Age 65 Retiree.

F. Interests not Transferable

The interests of Covered Persons under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, 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.

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 InforMed and the Claim Administrator. As directed by the Plan Administrator, InforMed 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 Article III of this Summary Plan Description).

(2) As directed by the Plan Administrator, initial determinations about benefits payable based on the specific terms of the Plan are made by InforMed 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 types 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 InforMed 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).

(4) As directed by the Plan Administrator, any internal appeal filed will be reviewed by InforMed 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).

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal 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 internal 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 Expense Incurred Date. 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 InforMed at (877) 234-5550 or by any method available for non-urgent and post-service 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 InforMed using one of the following methods:

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

Physical and Mailing Address:
InforMed, 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 InforMed 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 InforMed'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. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

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

(1) Urgent care appeals or requests for external review:

(a) Urgent care appeals or requests for external review related to claims denied due to lack of Medical Necessity may be submitted verbally by calling InforMed at (877) 234-5550 or by any method available for non-urgent and post-service appeals.

(b) Urgent care 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 and post-service appeals.

(2) Non-urgent care appeals or requests for external review, and post-service appeals or requests for external review:

(a) Non-urgent care appeals or requests for external review, and post-service appeals or requests for external review of claims denied due to lack of Medical Necessity must be in writing and must be submitted to InforMed using one of the following methods:

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

Physical and Mailing Address:
InforMed, LLC
1596 Whitehall Road
Annapolis, MD 21409

(b) Non-urgent care appeals or requests for external review, and post-service 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:	**Mailing Address:**
Health Plans, Inc. **1500 West Park Drive, Suite 330** **Westborough, MA 01581**	**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 or request for external review.

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 request 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 request 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 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.

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**	**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 to distribute such a summary annual financial report;

(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; and

(5) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the individual has Creditable Coverage from another plan. The individual should be provided a certificate of Creditable Coverage, free of charge, from the Plan when the individual loses coverage under the Plan, when the individual becomes entitled to elect COBRA continuation coverage, when his or her COBRA continuation coverage ceases, if the individual requests it before losing coverage, or if the individual requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, the individual may be subject to a pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after the individual's enrollment date in his or her coverage under the Plan.

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.

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.

APPENDIX A

The following services require precertification:

OUTPATIENT SERVICES, including the following:

- Speech therapy-beyond 8 visits
- Occupational therapy-beyond 8 visits
- Physical therapy -beyond 8 visits
- Home health care
- Home infusion therapy
- Growth hormone treatment
- Vein therapy
- Wound care
- Pain treatment
- Hemodialysis
- Radiation and chemotherapy
- EGD in Tier 2 or 3 facilities

DIAGNOSTIC TESTING, including the following:

- MRIs/MRAs in Tier 2 or 3 facilities
- Nuclear cardiology service in Tier 2 or 3 facilities
- PET/CAT scans in Tier 2 or 3 facilities

PROSTHETICS, ORTHOTICS, AND DURABLE MEDICAL EQUIPMENT or have your network supplier call

- Rent, purchase, or replace if cost exceeds $1,500 or rental beyond 3 months
- TENS unit
- Breast pump rental beyond 3 months

SAME-DAY SURGERIES, including the following:

- Cochlear implant
- Cosmetic/reconstructive surgery
- Outpatient transplants
- Carpel tunnel surgery
- Bone/spinal stimulation
- Bariatric, including lap-band, etc.

ALL INPATIENT SURGERY

ALL HOSPITAL/FACILITIY ADMISSIONS, including medical, surgical, behavioral health, substance abuse, skilled nursing and rehabilitation:

- At least two weeks prior to any planned surgery or admission
- Within 48 hours of an emergency hospital admission, or as soon as reasonably possible
- For illness or injury to newborns