Southcoast® Health Plan

Summary Plan Description

Employee Group Medical Plan (Value Plan)

Effective: January 1, 2020

www.Southcoasthealthplan.org

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SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN
VALUE EPO PLAN
AMENDMENT #8 TO THE
EFFECTIVE JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended to revise minimum age requirements routine colorectal cancer screenings. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV, SCHEDULE OF MEDICAL BENEFITS, PREVENTIVE CARE, Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies is hereby **deleted** and **replaced** in its entirety with the following**:**

PREVENTIVE CARE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
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.				
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.				
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 45 and older) See also Physician Services – Colonoscopy (Non-Routine) and Hospital Services/ Outpatient – Outpatient Surgery for Non-Routine Colonoscopy)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN
VALUE EPO PLAN
AMENDMENT #7 TO THE
EFFECTIVE JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2022

The Plan is amended in accordance with the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) to cover Emergency Care, Out-of-Network air ambulance services and certain non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility at the In-Network level of benefits, subject to the Qualifying Payment Amount; revise the definition of Allowed Amount and Emergency Care and add the definition of Qualifying Payment Amount; include continuity of care provisions for when a provider is no longer In-Network; and include final internal appeal denials related to compliance with the NSA as eligible for external review.

This Plan is also amended to include the following updates: update the URL for the HPI website; update orthotics benefit to clarify coverage for foot orthotics; refer Covered Persons to contact the Pharmacy vendor for assistance with formulary drug lists; and update the Plan's right of subrogation and reimbursement to ensure that the Plan is indemnified against attorney's fees, costs, or other expenses related to the recovery of funds. In addition, the Plan is also amended to apply the Deductible to Mental Health/Substance Abuse inpatient hospitalization; provide Covered Persons enrolled in the diabetic disease management program through Conifer with diabetic pumps, pump supplies and continuous glucose monitors and related supplies with no cost sharing. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION I, ESTABLISHMENT OF PLAN; The Plan is hereby amended as follows:

The HPI website URL is updated to www.hpiTPA.com. All references to this website are updated throughout the document.

SECTION III, DEFINITIONS; The definitions of **Allowed Amount** and **Emergency Care** are hereby **deleted** and **replaced** in their entirety with the following:

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are **not** subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "Non-NSA Covered Services"), minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. See the definition of "Qualifying Payment Amount" for the Covered Services that are subject to the NSA.

The Allowed Amount for Non-NSA Covered Services received from an Out-of-Network Provider depends upon where the services are provided.

> If Non-NSA Covered Services are received from an Out-of-Network Provider in New England, the Allowed Amount is an amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements and geographic adjustments.
>
> If Non-NSA Covered Services are received from an Out-of-Network Provider located outside of New England, the Allowed Amount is applied based on the following order of payment:
>
> - Fee(s) that are negotiated with the Physician or facility;

- 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic area; or

- 50% of the billed charges

The specific reimbursement formula used for services provided by an Out-of-Network Provider located outside of New England will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Covered Persons may be responsible for paying excess charges above the Allowed Amount for Non-NSA Covered Services after the Plan pays its portion.

Emergency Care – care administered in a Hospital, independent freestanding emergency department, clinic, urgent care center, or Physician's office for a Medical Emergency. Emergency Care includes: (1) an appropriate medical screening examination, including ancillary services routinely available to evaluate whether a Medical Emergency exists; and (2) such further medical examination and treatment as may be required to stabilize the Covered Person (regardless of the department of a Hospital or independent freestanding emergency department in which the further medical examination and treatment is furnished). Emergency Care does not include ambulance service to the facility where treatment is received.

SECTION III, DEFINITIONS; The definition of **Qualifying Payment Amount** is hereby **added** in its entirety:

Qualifying Payment Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services that are subject to the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA) (hereinafter referred to as "NSA Covered Services"). Such NSA Covered Services are: emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the NSA. The NSA Covered Services will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

The Qualifying Payment Amount will be based on the median of the contracted rate for the same or similar item or service provided by a Provider in the same or similar specialty in the same geographic region. If there are insufficient (meaning at least three) contracted rates available to determine a Qualifying Payment Amount, said amount will be determined by referencing a state all-payer claims database or, if unavailable, any eligible third-party database in accordance with applicable law. The Qualifying Payment Amount will be determined in accordance with the NSA, as amended. If the provider does not accept the Qualifying Payment Amount as payment in full for NSA Covered Services, the amount payable may be determined by a Certified IDR Entity. A "Certified IDR Entity" shall mean an entity responsible for conducting determinations under the NSA and that has been properly certified in accordance with the NSA, as amended. Any amendments to the foregoing methodology will be deemed to be included and in effect for the Plan as of the NSA amended date.

When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's In-Network level of benefits, subject to the Allowed Amount.

<u>SECTION IV</u>, SCHEDULE OF MEDICAL BENEFITS; MENTAL HEALTH/SUBSTANCE ABUSE and **OTHER SERVICES & SUPPLIES:**

- **MENTAL HEALTH/SUBSTANCE ABUSE - Inpatient Hospitalization** is hereby **deleted** and **replaced** in its entirety with the following:

MENTAL HEALTH/ SUBSTANCE ABUSE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty*, unless otherwise noted.* ***Procedures that are not Medically Necessary will not be covered.*** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**				
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.				
Inpatient Hospitalization *(Precertification required)*	100% coverage (after Deductible)	100% coverage (after Deductible)	100% coverage (after Deductible)	Not Covered

- **OTHER SERVICES & SUPPLIES – Durable Medical Equipment, Other Medical Supplies** and **Orthotics** are hereby **deleted** and **replaced** in their entirety with the following:

OTHER SERVICES & SUPPLIES	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.				
Durable Medical Equipment *(Precertification required for equipment in excess of $1,500, rentals exceeding three (3) months, TENS units must be precertified; see also* Insulin Pumps*, see* Medical Benefits *section for other limitations)*	Not available	80% coverage (Deductible waived) Covered Persons enrolled in the diabetic disease management program with Conifer receive diabetic pumps, pump supplies and continuous glucose monitors and related supplies at 100% coverage (Deductible waived)	60% coverage (after Deductible) Covered Persons enrolled in the diabetic disease management program with Conifer receive diabetic pumps, pump supplies and continuous glucose monitors and related supplies at 100% coverage (Deductible waived)	Not covered

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Out-of-Network Providers will be paid at In-Network Provider levels, subject to the Qualifying Payment Amount, for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility, provided the Covered Person has not validly waived the applicability of the NSA.				
Other Medical Supplies (Including diabetic supplies, ostomy and colostomy supplies)	100% coverage (Deductible waived) Covered Persons enrolled in the diabetic disease management program with Conifer receive diabetic pumps, pump supplies and continuous glucose monitors and related supplies at 100% coverage (Deductible waived)	100% coverage (Deductible waived) Covered Persons enrolled in the diabetic disease management program with Conifer receive diabetic pumps, pump supplies and continuous glucose monitors and related supplies at 100% coverage (Deductible waived)	60% coverage (after Deductible) Covered Persons enrolled in the diabetic disease management program with Conifer receive diabetic pumps, pump supplies and continuous glucose monitors and related supplies at 100% coverage (Deductible waived)	Not covered
Orthotics *(*Foot orthotics are covered; *Purchases of $1,500 or more must be precertified)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

SECTION V, MEDICAL BENEFITS, A. Benefit Levels;

- **In-Network Providers, Out-of-Network Providers** and **Traveling Benefit** are hereby **deleted** and **replaced** in its entirety with the following; and **No Surprises Billing** and **Continuity of Care** provisions are hereby **added** in their entirety with the following:

  Tier 1, Tier 2 and Tier 3 In-Network Providers – If a Covered Person has incurred Covered Services rendered by an In-Network Provider, the Plan will pay the Coinsurance amount as shown in the Schedule of Medical Benefits subject to the Contracted Rate (after satisfaction of the Calendar Year Deductible). **If you choose to receive services from an Out-of-Network Provider, no benefits will be paid, except for emergency medical care, urgent care, and certain covered ancillary benefits described in the Schedule of Medical Benefits and as set forth below. All other services rendered by an Out-of-Network Provider are not covered under this Plan, unless stated otherwise.**

  No Surprises Billing - Covered Services that are emergency services rendered by Out-of-Network Providers for "Emergency Care" as defined in the section titled "Definitions"; air ambulance services rendered by Out-of-Network Providers of air ambulance services; and non-emergency services rendered by Out-of-Network Providers on an inpatient or outpatient basis at an In-Network Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, provided the Covered Person has not validly waived the applicability of the No Surprises Act of the Consolidated Appropriations Act of 2021 (NSA), will be paid at the In-Network Provider Deductible, Co-payment and Coinsurance levels, subject to the Qualifying Payment Amount.

  When emergency services are rendered by an Out-of-Network Provider for Emergency Care, or air ambulance services are rendered by an Out-of-Network Provider of air ambulance services, the Out-of-

Network Provider cannot balance bill the Covered Person. When non-emergency services are rendered by an Out-of-Network Provider on an inpatient or outpatient basis at a Tier 1, Tier 2 or Tier 3 Hospital or facility for emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services, the Out-of-Network Provider cannot balance bill the Covered Person unless the Covered Person gives written consent and gives up their protections in accordance with the NSA. If a Covered Person waives their protections and agrees to balance billing per the NSA, Out-of-Network Providers will be paid according to the Plan's Tier 1, Tier 2 or Tier 3 level of benefits, subject to the Allowed Amount.

When services are rendered by an Out-of-Network Provider in any instance other than the reasons listed above, Covered Persons may be responsible for any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.

Out-of-Network (Tier 4)
Out-of-Network providers, will be paid at Tier 1, 2 or 3 Provider Deductible, Co-payment and Coinsurance levels subject to the Contracted Rate, Allowed Amount or Qualifying Payment Amount, as applicable, when covered ancillary medical services are rendered to a Covered Person on an inpatient or outpatient basis in a corresponding Tier 1, 2 or 3 Hospital or facility. Covered 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.

In addition, Out-of-Network Providers will be paid at Tier 1, Tier 2 or Tier 3 In-Network Provider Deductible, Co-payment and Coinsurance levels in the case of "Emergency Care" as defined in the section titled "Definitions". Covered 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 country and requires medical treatment from an Out-of-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 the Tier 3 Provider Co-payment and Coinsurance levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the applicable Calendar Year Deductible).

Continuity of Care - In the event a Covered Person is a continuing care patient receiving a course of treatment from a Provider which is In-Network or otherwise has a contractual relationship with the Plan governing such care and that contractual relationship is terminated, not renewed, or otherwise ends for any reason other than the Provider's failure to meet applicable quality standards or for fraud, the Covered Person shall have the following rights to continuation of care.

For purposes of this provision, "continuing care patient" means an individual who:

1) is undergoing a course of treatment for a serious and complex condition from a specific Provider,
2) is undergoing a course of institutional or inpatient care from a specific Provider,
3) is scheduled to undergo non-elective surgery from a specific Provider, including receipt of postoperative care with respect to the surgery,
4) is pregnant and undergoing a course of treatment for the Pregnancy from a specific Provider, or
5) is or was determined to be terminally ill and is receiving treatment for such illness from a specific Provider.

Note that during continuation, Plan benefits will be processed as if the termination had not occurred. However, the Provider may be free to pursue the Covered Person for any amounts above the Plan's benefit amount.

SECTION V, MEDICAL BENEFITS, C. Covered Services:

- **(1) Prescription Drugs;** The following provision is hereby **added** in its entirety:

  The presence of a drug on the Prescription Benefit Manager's formulary list does not guarantee coverage. The drugs listed on the Prescription Benefit Manager's formulary are subject to change. To find out if a medication is covered under the Plan, Covered Persons should contact the Pharmacy vendor at the phone number list on the back of his/her ID card for the most current formulary information.

- **(4) Physician Services; (j) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (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 as follows:

  (i) For In-Network Tier 1, 2 and 3 Providers: the Contracted Rate for the primary procedure and the greater of 50% of such Contracted Rate or the amount specified in the In-Network Provider's contract for the secondary or lesser procedure(s).

  (ii) For Out-of-Network Providers: the Allowed Amount, Contracted Rate or Qualifying Payment Amount, as applicable, for the major procedure and 50% of the Allowed Amount or Qualifying Payment Amount, as applicable, 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.

SECTION XII, THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT, C. Right of Reimbursement, paragraph (2) is hereby **deleted** and **replaced** in its entirety with the following:

C. Right of Reimbursement

(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. Additionally, the Participant shall indemnify the Plan against any of the Participant's attorney's fees, costs, or other expenses related to the Participant's recovery for which the Plan becomes responsible by any means other than the Plan's explicit written consent

<u>SECTION XV</u>, CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby amended as follows:

Final internal appeal denials related to compliance with the No Surprises Act of the Consolidated Appropriations Act of 2021 are added as denials eligible for external review.

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #6 TO THE
RESTATED JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2021

This Plan is amended to revise the Preventive Care – Abdominal Aortic Aneurysm Screening coverage to include women. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, PREVENTIVE CARE, Abdominal Aortic Aneurysm Screening is hereby **deleted** and **replaced** in its entirety with the following**:**

PREVENTIVE CARE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
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** (Age 65 and over) Up to one (1)* per person, per lifetime	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #5 TO THE
RESTATED JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2021

This Plan is amended to include the following updates: change the Prescription Drug Co-payments and Prescription Out-of-Pocket Maximums; add a visit limit to Chiropractic Services; add coverage for Acupuncture; revise the precertification requirement for Outpatient Surgery in Hospital, Ambulatory Surgical Center etc.; extend telemedicine services to include coverage for e-Visits/virtual visits; add virtual and online wellbeing programs and classes to the Fitness Reimbursement Benefit; revise the Medical Limitations and Exclusions, Coordination of Benefits and Third Party Recovery, Subrogation and Reimbursement Provisions sections to address payment and coordination of expenses incurred in connection with an automobile accident related to mandatory no-fault automobile insurance; and add provisions for continuation of coverage for state-mandated leave of absence add provisions for continuation of coverage for state-mandated leave of absence. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS is amended as follows:

- **Prescription Drug Benefit** is hereby **deleted** and **replaced** in its entirety:

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY CAREMARK	
Prescription Drug Expense & Mail Order Option **Mandatory Mail Order:** All maintenance prescriptions are allowed a maximum of two (2) 30 day supplies filled at any network pharmacy. All subsequent 30 day supplies must be filled at Southcoast Pharmacy. Prescriptions filled at Health Care Pharmacy, at Truesdale, and controlled substances are exempt from this requirement. 90 day supplies of maintenance medications may be filled at Southcoast Pharmacy (at the lowest cost), PPS Home Delivery (mail order pharmacy) or network pharmacy (at 3 times the monthly copay). **Clinical Prior Authorization Program:** Certain prescriptions require "clinical prior authorization" or approval from the Plan before they will be covered. To confirm whether a prescription needs clinical prior authorization and/or to request approval, please call (844) 282-5341. Please have available the name of the medication, physician's name, phone number (and fax number, if available), member ID number and group number (from member ID card). Note: Prescription drug Co-payments accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% coverage for the balance of the Calendar Year. Covered generic and single-source brand name contraceptive medications and devices are covered at 100% coverage Tobacco cessation products are covered at 100% coverage	**Up to a 30 day supply:** **Southcoast Pharmacies** $10 Co-payment per generic^ drug; $30 Co-payment per preferred brand name drug; $75 Co-payment per non-preferred brand name drug. **CVS Caremark Network** $20 Co-payment per generic drug; $60 Co-payment per preferred brand name drug; $120 Co-payment per non-preferred brand name drug. **Up to a 90 day supply:** **Southcoast Pharmacies** $25 Co-payment per generic^ drug; $75 Co-payment per preferred brand name drug; $187.50 Co-payment per non-preferred brand name drug. **CVS Caremark Mail Service** $50 Co-payment per generic drug; $150 Co-payment per preferred brand name drug; $300 Co-payment per non-preferred brand name drug. **Specialty Drugs:** **Southcoast Specialty** $50 Co-payment per generic drug; $100 Co-payment per preferred brand name drug; $250 Co-payment per non-preferred brand name drug. **CVS Specialty** $275 Co-payment per generic and brand name drug ^ Generics: some generics are available at a lower cost at Southcoast Pharmacies.
Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums: (Includes all applicable prescription drug Co-payments)	$2,400 per person $4,800 per Employee +1 Up to $4,800 per family
Out-of-Network Pharmacy Coverage	Yes, see CVS Caremark Network above

- **PHYSICIAN SERVICES, Chiropractic Services** is hereby **deleted** and **replaced** in its entirety**:**

PHYSICIAN SERVICES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Chiropractic Services Up to 12* visits per person, per Calendar Year	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

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

- **HOSPITAL SERVICES – OUTPATIENT, Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc** is hereby **deleted** and **replaced** in its entirety:

HOSPITAL SERVICES – OUTPATIENT	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty, unless otherwise noted. Procedures that are not Medically Necessary will not be covered. **Oncology Treatment (including Office Visits):** Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**				
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (*Precertification may be required; contact Conifer to verify*)	100% coverage (after Deductible)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
	Non-Routine Colonoscopies performed at Tier 1: Southcoast Hospitals and Physicians Network are covered 100% coverage (Deductible waived). *Precertification is not required.*			

- **OTHER SERVICES & SUPPLIES, Acupuncture** is hereby **added** in its entirety; **Telemedicine** is hereby **deleted** and **replaced** in its entirety:

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Acupuncture Up to 12* visits per person, per Calendar Year	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Telemedicine (S*ee* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	Not covered Not Covered

Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	Paid based on services provided	Paid based on services provided	Paid based on services provided	

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

- **WELLNESS BENEFITS, Fitness Reimbursement Benefit** is hereby **deleted** and **replaced** in its entirety:

WELLNESS BENEFITS	ALL PROVIDERS
Fitness Reimbursement Benefit	100% coverage up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees, virtual and online wellbeing programs/classes or qualified yoga classes. (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 or have attended at least four (4) qualified yoga classes and have been on this plan for at least four (4) consecutive months to be eligible for reimbursement.)

SECTION V. MEDICAL BENEFITS, C. Covered Services, (10) Other Covered Services and Supplies:

- **Acupuncture** is hereby **added** in its entirety.

- **Telemedicine services** is hereby **deleted** and **replaced** in its entirety with the following:

Telemedicine services

Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between the Covered Person and the Provider. Telemedicine services are limited to the use of real-time interactive audio, video, or other electronic media telecommunications as a substitute for in-person consultation with Providers. Covered Services include:

(i) Telemedicine/telehealth visits

Interactive audio and video telecommunications system that permits real-time communication between a remote Provider and a Covered Person. Remote Providers who can furnish covered telehealth services (subject to state law) can include physicians, nurse practitioners, physician assistants, nurse midwives, certified nurse anesthetists, clinical psychologists, clinical social workers, registered dietitians, and nutrition professionals

(ii) e-Visits/virtual visits

Non-face-to-face patient-initiated communications with a Covered Person's doctor(s) without going to the doctor's office by using online patient portals. E-visits/virtual visits are covered when the Provider has an established relationship with the Covered Person

SECTION V. MEDICAL BENEFITS, C. Covered Services, (11) Wellness Benefits, (b) Fitness Reimbursement Benefit is hereby **deleted** and **replaced** in its entirety with the following:

100% coverage up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees, virtual and online wellbeing programs/classes or qualified yoga classes. (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 or have attended at least four (4) qualified yoga classes and have been on this plan for at least four (4) consecutive months to be eligible for reimbursement.)

SECTION VI. MEDICAL LIMITATIONS AND EXCLUSIONS; The following exclusion related to mandatory no-fault automobile insurance is hereby **added** in its entirety:

> Expenses incurred in connection with an automobile accident for which benefits payable hereunder are, or would be otherwise covered by, mandatory no-fault automobile insurance or any other similar type of personal injury insurance required by state or federal law, without regard to whether or not the Covered Person actually had such mandatory coverage. Any claims which arise in connection with an automobile accident for which the policy provides an option for medical coverage are excluded. Benefits will be excluded to the maximum amount of first party medical coverage available under the applicable state law, regardless of a Covered Person's election of lesser coverage. This exclusion does not apply if the injured Covered Person is a passenger in a non-family owned vehicle or a pedestrian.

SECTION VI. MEDICAL LIMITATIONS AND EXCLUSIONS; Acupuncture is hereby **deleted** in its entirety.

SECTION VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION, C. Participation, (1) Participation during Period of Leaves of Absence or Disability; Leave of Absence under State-Mandated Family or Medical Leave is hereby **added** in its entirety as follows:

> **Leave of Absence under State-Mandated Family or Medical Leave**
>
> A covered Employee who is absent from work due to an approved state-mandated family or medical leave, may continue to participate in this Plan for a period up to the maximum permissible timeframe under the applicable state-mandated family or medical leave, subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after the expiration of the leave or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

The above noted leave(s), with the exception of a Leave of Absence not meeting the definition of an FMLA Leave, do run concurrently with FMLA, USERRA or any State-mandated family or medical leave, and/or any other applicable leaves of absence.

SECTION VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION, C. Participation, (3) Participation in Cases of Return to Work or Reemployment; Return from State-Mandated Family or Medical Leave is hereby **added** in its entirety as follows:

> **Return from State-Mandated Family or Medical Leave**
>
> Participation in the Plan will begin immediately for any Covered Person who discontinued coverage during a leave of absence taken under a state-mandated family or medical leave by the Employee, provided the Employee returns to Actively at Work status before or immediately following the expiration of the state-mandated family or medical leave, and provided that the Employee is eligible for coverage upon return in accordance with the provisions of Section A of this Article, Eligibility.

SECTION VIII. COORDINATION OF BENEFITS is hereby **deleted** and **replaced** in its entirety with the following:

VIII. COORDINATION OF BENEFITS

A. Maximum Benefits Under All Plans

If any Covered Person 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 any Other 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 (if applicable) prescription drug claims which are administered by the Prescription Drug Manager for this Plan

B. Other Plan

"Other Plan" shall include, but is not limited to:

(1) Any primary payer besides this Plan;

(2) Any other group health plan;

(3) Any other coverage or policy covering the Covered Person;

(4) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

(5) Any policy of insurance from any insurance company or guarantor of a responsible party;

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

(7) Workers' compensation or other liability insurance company; and

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

C. Excess Insurance

If at the time of Injury, Illness, disease or disability there is available, or potentially available any other source of 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.

The Plan's benefits will be excess to, whenever possible, any of the following:

(1) Any primary payer besides this Plan;

(2) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

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

(4) Workers' compensation or other liability insurance company; and

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

D. Vehicle Limitation

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 and will exclude benefits subject to the Exclusions and Limitations provisions set forth in this Plan up to the maximum amount available to the Covered Person under applicable state law, regardless of a Covered Person's election of lesser coverage amount. This applies to

all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.

E. 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 as follows:

(1) The plan covering the Covered Person other than as an Eligible Dependent, for example as an Employee, member, subscriber, policyholder or 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 as an Eligible Dependent of the Employee) pays benefits first if such an individual is also being provided COBRA continuation coverage under any Other 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 the Other 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.

F. 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 this Plan must furnish any information that the Plan Sponsor may require

(2) May recover on behalf of this 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 this Plan have been made by such organization

G. 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 §1862(b) (42 U.S.C. §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 Services and when Medicare will be the primary payer.

In the event that this Plan would otherwise be allowed (as in accordance with the Medicare Secondary Payor rules) to be a secondary payor of Covered Services 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.

H. 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.

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

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

J. 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.

K. 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, this 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.

L. 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, a Covered Person may be required to provide confirmation regarding any other health coverage the Covered Person may have and must furnish information regarding such coverage as may be necessary to implement this provision. Until confirmation regarding any other coverage is provided, payment of the Covered Person's claims under this Plan may be delayed and claims may be denied if confirmation is not received. In addition, 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.

M. Facility of Payment

Whenever payments which should have been made under this Plan in accordance with this provision, have been made under any Other Plan, 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.

N. Right of Recovery

Whenever payments have been made by the Employer with respect to Covered Services 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.

SECTION XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS is hereby **deleted** and **replaced** in its entirety with the following:

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

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

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

(3) In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include payment for future treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical expenses.

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

B. Subrogation

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

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

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

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

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

(b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage, including any similar coverage under a different name in a particular state;

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

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

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

the Covered Person(s) authorizes the Plan to pursue, sue, compromise and/or settle any such claims in the Covered Person(s)' and/or the Plan's name and agrees to fully cooperate with the Plan in the prosecution of any such claims. The Covered Person(s) assigns all rights to the Plan or its assignee to pursue a claim and the recovery of all expenses from any and all sources listed above.

C. Right of Reimbursement

(1) The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal or equitable theory, and without regard to whether the Covered Person(s) is fully compensated by his/her recovery from all sources. The Plan shall have an

equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any State prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable lien and right to reimbursement. The obligation to reimburse the Plan in full exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses and extends until the date upon which the liable party is released from liability. If the Covered Person's(s)' recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved. Any funds received by the Covered Person(s) are deemed held in constructive trust and should not be dissipated or disbursed until such time as the Covered Person's(s') obligation to reimburse the Plan has been satisfied in accordance with these provisions. The Covered Person(s) is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.

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

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

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

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

D. Covered Person is a Trustee Over Plan Assets

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

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

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

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

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

(2) To the extent the Covered Person(s) disputes this obligation to the Plan under this section, the Covered Person(s) or any of his/her agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys' fees, for which he/she exercises control, in an

account segregated from their general accounts or general assets until such time as the dispute is resolved.

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

E. Release of Liability

The Plan's right to reimbursement extends to any incident related care that is received by the Covered Person(s) (Incurred) prior to the liable party being released from liability. The Covered Person's/Covered Persons' obligation to reimburse the Plan is therefore tethered to the date upon which the claims were Incurred, not the date upon which the payment is made by the Plan. In the case of a settlement, the Covered Person has an obligation to review the "lien" provided by the Plan and reflecting claims paid by the Plan for which it seeks reimbursement, prior to settlement and/or executing a release of any liable or potentially liable third party, and is also obligated to advise the Plan of any incident related care Incurred prior to the proposed date of settlement and/or release, which is not listed but has been or will be Incurred, and for which the Plan will be asked to pay.

F. 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 any of the following:

(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 under a different name in a particular state;

(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.

G. Separation of Funds

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

H. Wrongful Death

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

I. 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 Injury, Illness, disease, or disability, including accident reports, settlement information and any other requested additional information;

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

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

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

(f) To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan;

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

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

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

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

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

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

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

J. Offset

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

K. Minor Status

(1) In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

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

L. 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 with respect to this provision. The Plan Administrator may amend the Plan at any time without notice.

M. 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.

N. Definitions

For purposes of this Article XII, the following words and phrases will have the following meanings when used in the Plan under this Article XII, unless a different meaning is plainly required by the context.

Incurred - Covered Services are "Incurred" on the date the service is rendered or the supply is obtained. With respect to a course of treatment or procedure which includes several steps or phases of treatment, Covered Services are Incurred for the various steps or phases as the services related to each step are rendered and not when services relating to the initial step or phase are rendered. More specifically, Covered Services for the entire procedure or course of treatment are not Incurred upon commencement of the first stage of the procedure or course of treatment.

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #4 TO THE
RESTATED JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JANUARY 1, 2020

This Plan is amended to correct a scrivener's error regarding coverage for non-routine colonoscopies. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, PREVENTIVE CARE - Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies, PHYSICIAN SERVICES – Colonoscopy, and OTHER SERVICES AND SUPPLIES - Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. are hereby **deleted** and **replaced** in their entirety with the following:

PREVENTIVE CARE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
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 Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older) See also Physician Services – Colonoscopy (Non-Routine) and Hospital Services/ Outpatient – Outpatient Surgery for Non-Routine Colonoscopy)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
PHYSICIAN SERVICES	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Colonoscopy (Non-Routine)	100% coverage (Deductible waived)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not covered

HOSPITAL SERVICES – OUTPATIENT	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty, unless otherwise noted. Procedures that are not Medically Necessary will not be covered. **Oncology Treatment (including Office Visits):** Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**				
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (*Precertification is required*)	100% coverage (after Deductible)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
	Non-Routine Colonoscopies performed at Tier 1: Southcoast Hospitals and Physicians Network are covered 100% coverage (Deductible waived). *Precertification is not required.*			

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #3 TO THE
RESTATED JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JULY 1, 2020

This Plan is amended to clarify prescription drug coverage. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION V. MEDICAL BENEFITS, C. Covered Services, (1) Prescription Drugs, Note is hereby **deleted** and **replaced** in its entirety as follows:

Note: The following drugs are available through the Prescription Drug Benefit and are excluded from coverage under the Medical Plan; Anti-Hemophillic Factor VIII (J7192) and Alferon-N (J9216).

The following drugs are available through the Medical Plan only with prior authorization: Bevacizumb (J9035); Injection, trastuzumab, excludes biosimilar (J9355); Injection, rituximab,10 mg (J9312); Injection, pertuzumab, 1 mg (J9306); Injection, ocrelizumab, 1 mg (J2350); Denosumab injection (J0897); Aflibercept injection (J0178); Lanreotide injection (J1930); Fentanyl citrate injection (J3010); Injection, collagenase, clostridium histolyticum (J0775); Rituxamab (J9310); Natalizumab (J2323); Interferon (J3490); Injection, propofol, 10 mg (J2704); Ondansetron Hcl Injection (J2405); Injection, methylprednisolone acetate, 40 mg (J1030); Injection, ketorolac tromethamine (J1885); Dexamethasone sodium phosphate (J1100); Morphine sulfate injection (J2270); Cefazolin sodium injection (J0690); Injection, midazolam hydrochloride (J2250); Diphenhydramine Hcl injection (J1200); Cetuximab (J9055): Injection, heparin sodium per 1000u (J1644); Synvisc or Synvisc-One (J7325); and Euflexxa inj per dose (J7323)

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #2 TO THE
RESTATED JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: JUNE 18, 2020

This Plan is amended to remove reference to Southcoast Health On Call from Telemedicine. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, OTHER SERVICES & SUPPLLIES, Telemedicine is hereby **deleted** and **replaced** in its entirety as follows:

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Telemedicine	Not Covered	Doctor on Demand: $30 Co-payment, then 100% coverage (Deductible waived)	Not Covered	Not Covered

SOUTHCOAST HOSPITALS GROUP, INC.
EMPLOYEE GROUP MEDICAL PLAN (VALUE PLAN)
AMENDMENT #1 TO THE
JANUARY 1, 2020 SUMMARY PLAN DESCRIPTION
EFFECTIVE: APRIL 1, 2020

This Plan is amended to update the telemedicine benefit and clarify the Claims and Appeals Procedures. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Summary Plan Description is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS, OTHER SERIVES & SUPPLIES, Telemedicine is hereby **deleted** and **replaced** in its entirety as follows:

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Telemedicine	Southcoast Health On Call at oncall.southcoast.org: $10 Co-payment, then 100% coverage (Deductible waived)	Doctor on Demand: $30 Co-payment, then 100% coverage (Deductible waived)	Not covered	Not covered

SECTION XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS is hereby **deleted** and **replaced** in its entirety as follows:

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.

Designating an Authorized Representative

For initial claims
For the purposes of filing initial claims for coverage under the Plan, the health care provider who rendered services to the Covered Person is deemed to be an authorized representative, and most claims are filed by health care providers directly with the Claim Administrator. The Covered Person may also designate another person to be the authorized representative for filing claims by completing the applicable section of the Member Reimbursement form. The Member Reimbursement form can be completed online at the Plan web site shown on the Plan ID card; downloaded and printed; or requested from 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. Claims are subject to the filing limits described in this Article.

For appeals or requests for external review
For the purposes of filing appeals or requesting external review of denied Urgent Care Claims (defined below) on behalf of a Covered Person, the Covered Person's treating health care provider is deemed to be an authorized representative. The Covered Person may also name another individual as an authorized representative for appeals and external review by completing and submitting a Designation of Personal Representative Authorized for Claim Appeal and/or External Review Request form (DPR form), available upon request from the Claim Administrator. For a health care provider to appeal or request review of a non-Urgent Care Claim on behalf of the Covered Person, the Covered Person must execute a DPR form naming the provider as the authorized representative. After an

authorized representative has been designated, all subsequent notices and decisions concerning appeals or requests for external review will be provided to the Covered Person through his or her authorized representative.

Exhaustion of Internal Appeals Required

Under this Plan, there are two levels of mandatory internal appeals. A Covered Person is required to exhaust both levels of the internal appeals process before requesting an external review or pursuing other legal remedies that may be available except in the following situations: 1. In cases involving Urgent Care Claims, the Covered Person may forego the internal appeals process and request an expedited external review upon receipt of the initial claim denial and 2. In cases where the Plan has not adhered to the claims and appeals requirements specified in this Plan and the violation is more than *de minimis*, the internal review process may be deemed to be exhausted and the Covered Person may initiate an external review or take other available legal action. Appeals, requests for external review and other legal actions are subject to the filing periods described in this Article and the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

Claims and Appeals Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to Conifer and the Claim Administrator. As directed by the Plan Administrator, Conifer makes initial claim and initial and second level appeal determinations of Medical Necessity, the Prescription Benefit Manager for prescription claims, and the Claim Administrator makes initial claim and initial and second level 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 (as defined in the Article titled "Definitions" of this Summary Plan Description).

(2) As directed by the Plan Administrator, initial determinations about benefits payable based on the specific terms of the Plan are made by Conifer for claims that require precertification of Medical Necessity, for prescription claims the Prescription Benefit Manager, 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, it is called an 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. If the Covered Person disputes the determination, he or she may confirm that the claim was properly processed by contacting Conifer regarding claims denied based on a lack of Medical Necessity, the Prescription Benefit Manager for prescription claims, 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). Note that in cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the internal appeals process and request an expedited external review *(see 6 below)*.

(4) As directed by the Plan Administrator, any internal appeal filed will be reviewed by Conifer regarding claims denied due to a lack of Medical Necessity, or the Prescription Benefit Manager for prescription claims, 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 with either Conifer or the Claim Administrator for medical claims, or the Prescription Benefit Manager for prescription claims, within the time periods specified in Chart B, below. In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the second internal appeal and request an expedited external review (see 6 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 required (except as described under *Exhaustion of Internal Appeals Required* above) and 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, or if the initial denial was for an Urgent Care Claim, 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. The Covered Person may also elect to take legal action as may be available under § 502(a) of ERISA or under other state or federal law instead of or following external review, provided such action is initiated within the time period described under the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

A. Who May File a Claim

A Covered Person's health care service provider may submit claims, and most claims are submitted by providers directly to the Claim Administrator. Alternatively, a claim may be filed by a Covered Person, or by his or her authorized representative. See *Designating an Authorized Representative*, above. 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.

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 allowed or making non-Urgent Care Claim 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 Covered Person 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 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 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

An initial claim for inpatient benefits must be submitted by the Covered Person, or by the Covered Person's health care provider or other authorized representative, no later than one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims

received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

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

(1) Urgent Care Claims, including Urgent Concurrent Care Claims:

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

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

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

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

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

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

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

D. Initial Claim Determination

After a claim has been submitted to Conifer or the Claim Administrator, the Plan will make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond Conifer's or the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the Covered Person 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 Covered Person of improperly filed claim or missing information**	**Period for Covered Person 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*
NON-URGENT CONCURRENT AND PRE-SERVICE 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.
**Provided 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 Covered Person may file an internal appeal of the adverse benefit determination. In making an appeal or request for external review, the Covered Person has the right to designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review. See *Designating an Authorized Representative* at the beginning of this section.

Before filing an appeal, a Covered Person may first want to contact the Claim Administrator at (877) 234-5550, or the Prescription Benefit Manager for prescription claims, 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, or in cases involving Urgent Care, may be filed upon receipt of the initial claim 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) can be filed depends on the type of appeal or request for external review:

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

(a) Urgent Care Claim appeals or requests for external review related to claims denied due to lack of Medical Necessity and any Post-Service Claim appeals may be submitted either

verbally by calling Conifer at (877) 234-5550 or by any method available for non-urgent appeals or verbally by calling the Prescription Benefit Manager for prescription claims. Upon request, Urgent Care Claim denials based on a medical judgment may be submitted for external review either upon receipt of the initial claim denial, after the first internal appeal or after completing the internal appeals process.

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

(2) Non-Urgent Care, Pre-Service and Post-Service Care Claim appeals or requests for external review: Call the Prescription Benefit Manager for prescription appeals as shown below.

(a) Non-Urgent Care, Pre-Service and Post-Service Claim appeals or requests for external review of claims denied due to lack of Medical Necessity must be in writing and must be submitted to Conifer using one of the following methods:

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

Medical Appeals	
Clinical Appeals: **Physical and Mailing Address:** Conifer Value-Based Care, LLC 1596 Whitehall Road Annapolis, MD 21409	**Physical Address:** Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 **Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581
Prescription Inquiries/Prior Authorization/Appeals	
Covered Persons should contact the Prescription Benefit Manager directly at the telephone number listed on his/her ID card for directions on submitting appeals.	

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

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

Physical Address:	**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 the 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 Covered Person 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 Covered Person 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 Covered Person will have 60 days to request a second appeal. Alternatively, in cases involving Urgent Care Claim denials based on medical judgment, a Covered Person may forego the second internal appeal and request an external review. In filing a second appeal, the Covered Person 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 Covered Person 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 Covered Person will have 4 months to request an external review. In filing a request for an external review, the Covered Person 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 Covered Person, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is eligible for external review, the Plan will assign the review to an IRO on a random basis, rotating assignments among IROs. The IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.

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

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

CHART B
Time Limits Regarding Initial and Second Internal Appeals and Request for External Review

Type of Claim	Maximum period for Covered Person to file initial internal appeal after initial denial	Maximum period for issuing determination regarding initial appeal	Maximum period for Covered Person 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 Covered Person to file request for external review following denial of final appeal*	Maximum period for issuing determination regarding external review
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	For denials involving medical judgment, Covered Persons may request expedited external review upon the initial claim denial, upon the first appeal denial, or may request external review within 4 months of the final internal appeal determination	72 hours
NON-URGENT CONCURRENT CARE AND PRE-SERVICE 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; and

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

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

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

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

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

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.

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

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

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

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

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

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

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

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

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

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

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

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

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

SUMMARY OF MATERIAL MODIFICATIONS (SMM)
EFFECTIVE JANUARY 15, 2022

The Medical Benefit Plan(s) offered by the Plan Sponsor and administered by Health Plans, Inc. are amended to include coverage for at-home over-the-counter COVID-19 tests in accordance with the terms the Families First Coronavirus Response Act (FFCRA), the Coronavirus Aid, Relief, and Economic Security Act (CARES Act), and the Affordable Care Act, as applicable. The provisions below have been adopted by the Plan Sponsor and are in addition to, and supersede, any contrary provisions detailed in the Plan Document(s) and/or Summary Plan Descriptions.

The Plan(s) are hereby amended to include the provisions below:

Coverage for at-home over-the counter COVID-19 testing includes the following:

- Coverage of FDA approved at-home over-the-counter COVID-19 tests without any cost sharing (e.g. deductibles, copayments or coinsurance), prior authorization or other medical management requirements (hereinafter referred to as "At-Home COVID Tests").
- Coverage for At-Home COVID Tests is provided directly through the Plan's Prescription Benefits Administrator's (PBM) pharmacy network or preferred retailers with no upfront out of pocket costs.
- If the network pharmacy does not have any At-Home COVID Tests available or the pharmacy has not implemented operations to support direct coverage, Covered Persons can purchase At-Home COVID Tests at an out of network pharmacy or on-line and submit to the PBM for reimbursement which will be limited to the lesser of the cost of the test or $12.
- Coverage for At-Home COVID Tests is provided exclusively through the PBM benefit. At-Home COVID Tests are not otherwise covered or reimbursable under the Plan.
- The Plan will cover up to 8 At-Home COVID Tests per Covered Person, per 30-day period.

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 (Value Plan), a component of the Southcoast Hospitals Group, Inc. Employee Benefit Plan (Plan No. 603), effective as of January 1, 2020 (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.

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

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

II. GENERAL INFORMATION

Plan Name:	Southcoast Hospitals Group, Inc. Employee Group Medical Plan (Value 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, 2020
Employer/Plan Sponsor:	Southcoast Hospitals Group, Inc. (the "Employer") 101 Page Street New Bedford, MA 02740-3464 (508) 997-1515
ERISA Plan Number:	603
Employer Identification Number:	22-2592333
Group Number:	006SHP
Plan Administrator:	Employer (see above)
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (877) 234-5550
Prescription Benefit Manager:	Caremark 687 E. Allenton Road Kingstown, RI 02852 (888) 862-2699
Case Management Services:	Conifer Value-Based Care, LLC (hereafter referred to as "Conifer") 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
ERISA Plan Year Ends:	December 31st
Fiscal Year Ends:	September 30th
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized Officer of the Employer. An Employee's consent is not required to terminate or change the Plan. Coverage otherwise ends as described in Article X, Termination and Continuation of Coverage. Contact the Plan Administrator to discuss what benefit extensions may apply or what arrangements may be made to continue coverage. In general, coverage may not be retroactively terminated under this Plan, except in cases of: a) fraud or intentional misrepresentation of material fact related to an Employee's or his or her dependents' eligibility for coverage under the Plan, b) failure to notify the Plan about a dependent's loss of eligibility for coverage under the Plan in a timely manner, or c) failure to pay required premiums or contributions in a timely manner. If coverage is retroactively terminated for any of these reasons, an Employee may be responsible for any benefit payments made during the relevant period. For any rescission (retroactive termination of coverage that is related to fraud or intentional misrepresentation) the Plan Administrator will provide thirty (30) days advance written notice and an Employee will have the right to appeal the Plan's termination of coverage.

III. DEFINITIONS

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

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.

Allowed Amount – the maximum amount the Plan will pay an Out-of-Network Provider for Covered Services minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan. The Allowed Amount for services received from an Out-of-Network Provider depends upon where the services are provided. Covered Persons may be responsible for paying the balance of these claims after the Plan pays its portion, if any.

Services Received In New England

If the services are received from an Out-of-Network Provider in New England, the Allowed Amount is defined as follows:

An amount that is consistent with the normal range of charges by health care Providers for the same or similar, products or services in a given geographic area provided to a Covered Person. Allowed Amounts are based on data from a national database of medical and dental charges which is periodically updated.

Services Received Outside New England

If the services are received from an Out-of-Network Provider located outside of New England, the Allowed Amount is defined as the lower of one of the following:

- Fee(s) that are negotiated with the Physician or facility;
- 200% of the published rates allowed by the Centers for Medicare and Medicaid Services (CMS) for Medicare for the same or similar service within the geographic area; or
- 50% of the billed charges

The specific reimbursement formula used for services provided by an Out-of-Network Provider located outside of New England will vary depending upon the Physician or facility providing the service(s) and the type of service(s) received.

Approved Clinical Trial – a phase I, phase II, phase III, or phase IV clinical trial that is conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition and is one of the following:

(1) Federally funded or approved

(2) Conducted under a Food and Drug Administration (FDA) investigational new drug application; or

(3) Drug trials which are exempt from the requirements of an FDA investigational new drug application

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.

Calendar Year – the time period beginning January 1st and ending December 31st

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.

Contracted Rate – the negotiated amount the Plan has agreed to pay an In-Network Provider for Covered Services minus any applicable Coinsurance, Co-payment or Deductible a Covered Person may be responsible for under the Plan

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

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

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

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

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

Eligible Dependents of Employees-

(1) An Employee's Spouse

If Spouses 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 may cover Eligible Dependent children, if any.

Divorced Spouses are ***not eligible*** for coverage under this Plan even if a court judgment governing the terms of the divorce requires the Employee to provide health coverage for the former Spouse. Eligibility in the Plan will be terminated.

(2) An Employee's child under age 26

(3) An Employee's unmarried child age 26 or older who is Permanently and Totally Disabled, whose disability began before age 26, who is not eligible to enroll in another employer-sponsored group health plan, other than the group health plan of either parent, 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 by a court of competent jurisdiction;

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.

(d) Child for whom legal guardianship has been awarded to the Employee or to the Spouse by a court of competent jurisdiction; or

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

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 §1908 of the Social Security Act (as added by §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 § 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 generally does not recognize former Spouses, legally-separated Spouses, civil union or domestic partners, or the children of these partners, as dependents under the federal tax code unless the Spouse, partner or child otherwise qualifies as a dependent under the Internal Revenue Code §152. Therefore, the Employer may be required to automatically include the value of the health care coverage provided to any of the aforementioned individuals, who are covered under this Plan as 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 an Approved Clinical Trial, are consistent with that standard of care for someone with the patient's diagnosis, are consistent with the study protocol for the Approved Clinical Trial and would be covered if the patient did not participate in the Approved 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

In-Network Provider – a member of a network of Physicians, other licensed health care providers and/or health care facilities which provide medical services to Covered Persons under this Plan on the basis of a Contracted Rate; Covered Persons receiving Covered Services from an In-Network Provider are not responsible for any charges other than the cost sharing requirements (Deductibles, Coinsurance and/or Co-payments) and charges in excess of any specific benefit limits shown in the Schedule of Medical Benefits

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

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

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

(3) Provides pre-death and bereavement counseling;

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

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

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

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

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

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

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

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

(3) Not Experimental or Investigational; and

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

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

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

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

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

New England – the states of Massachusetts, New Hampshire, Maine, Vermont, Connecticut and Rhode Island

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-Network Provider – a licensed Physician, other licensed health care provider and/or health care facility which is not a member of a network of participating providers which provide medical services to Covered Persons under this Plan on the basis of a Contracted Rate; Covered Persons receiving Covered Services from an Out-of-Network Provider are responsible for any applicable Deductibles, Coinsurance and/or Co-payments, amounts in excess of any specific benefit limits shown in the Schedule of Medical Benefits for Out-of-Network Providers, and may

be responsible for any amounts in excess of the Allowed Amount for the services received, unless specifically stated otherwise in this Plan

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 (12) 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.

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

Skilled Nursing Facility – a licensed facility which:

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

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

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

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

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

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

Spouse - an individual married to a person of the opposite sex or same sex if the couple is lawfully married under state (or foreign) law as defined under federal tax provisions; however, individuals who have entered into a registered domestic partnership, civil union, or other similar relationship that is not considered a marriage under state (or foreign) law are not considered Spouses for federal tax purposes; for more details, see IRS Publication 501

Tiering:
Tier 1- Southcoast Hospitals & Physicians Network:

Boston Children's Hospital (MA)
Charlton Memorial Hospital (MA)
St. Luke's Hospital (MA)
Southcoast Behavioral Health (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)
Beth Israel Plymouth 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)
Concord Hospital (NH)
Cottage Hospital (NH)
Dana-Farber Cancer Institute (MA)
Elliot Hospital (NH)
Emerson Hospital (MA)
Exeter Hospital (NH)
Falmouth Hospital (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)
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)
Mary Hitchcock Memorial Hospital (NH)
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)
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 Providers:

Androscoggin Valley Hospital (NH)
Berkshire Medical Center (MA)
Brigham & Women's Hospital (MA)
Cooley Dickinson Hospital (MA)
Duncan Lodge (RI)
Eleanor Slater Hospital (RI)
Fairview Hospital (MA)
Faulkner Hospital (MA)
Franklin Medical Center (MA)
Littleton Regional Hospital (NH)
Martha's Vineyard Hospital (MA)
Massachusetts General Hospital (MA)
Memorial Hospital (NH)
Nantucket Cottage Hospital (MA)
New England Baptist Hospital (MA)
Portsmouth Regional Hospital (NH)
Providence VA Medical Center (RI)
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)

Out-of-Network Providers (Tier 4)

Steward Physicians and Hospitals
Out-of-Network Physicians and Hospitals are excluded in New England unless noted otherwise
Providers outside New England must be in the United Health Care Options Network

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

Transplant Benefit Period – the period which begins on the date of the initial evaluation and ends on the date which is twelve (12) consecutive months following the date of the transplant; if

the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant

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

Waiting Period – the period of time, if any, an Employee must be employed by the Employer before becoming eligible to participate in this Plan

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 Conifer 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, unless otherwise noted. 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. If services rendered in an inpatient Hospital setting exceed the number of days precertified and the Hospital's reimbursement arrangement for those services is based on the diagnostic related group (DRG) pricing, the inpatient services will be paid according to the DRG priced amount. 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 Conifer 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.

Any penalty incurred due to failure to obtain notification or obtain a prior authorization for Covered Services is the Covered Person's responsibility.

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

Boston Children's Hospital (MA)
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Southcoast Behavioral Health (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

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Beth Israel Deaconess Hospital (MA)
Beth Israel Needham Campus (MA)
Beth Israel Plymouth 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)
Concord Hospital (NH)
Cottage Hospital (NH)
Dana-Farber Cancer Institute (MA)
Elliot Hospital (NH)
Emerson Hospital (MA)
Exeter Hospital (NH)
Falmouth Hospital (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)
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)
Mary Hitchcock Memorial Hospital (NH)
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)
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 Providers

Androscoggin Valley Hospital (NH)
Berkshire Medical Center (MA)
Brigham & Women's Hospital (MA)
Cooley Dickinson Hospital (MA)
Duncan Lodge (RI)
Eleanor Slater Hospital (RI)
Fairview Hospital (MA)
Faulkner Hospital (MA)
Franklin Medical Center (MA)
Littleton Regional Hospital (NH)
Martha's Vineyard Hospital (MA)
Massachusetts General Hospital (MA)
Memorial Hospital (NH)
Nantucket Cottage Hospital (MA)
New England Baptist Hospital (MA)
Portsmouth Regional Hospital (NH)
Providence VA Medical Center (RI)
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)

Out-of-Network Providers (Tier 4)

Steward Physicians and Hospitals
Out-of-Network Physicians and Hospitals are excluded in New England unless noted otherwise.
Providers outside New England must be in the United Health Care Options Network

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 CAREMARK	
Prescription Drug Expense & Mail Order Option **Mandatory Mail Order:** All maintenance prescriptions are allowed a maximum of two (2) 30 day supplies filled at any network pharmacy. All subsequent 30 day supplies must be filled at Southcoast Pharmacy. Prescriptions filled at Health Care Pharmacy, at Truesdale, and controlled substances are exempt from this requirement. 90 day supplies of maintenance medications may be filled at Southcoast Pharmacy (at the lowest cost), PPS Home Delivery (mail order pharmacy) or network pharmacy (at 3 times the monthly copay). **Clinical Prior Authorization Program:** Certain prescriptions require "clinical prior authorization" or approval from the Plan before they will be covered. To confirm whether a prescription needs clinical prior authorization and/or to request approval, please call (844) 282-5341. Please have available the name of the medication, physician's name, phone number (and fax number, if available), member ID number and group number (from member ID card). Note: Prescription drug Co-payments accumulate toward the prescription drug Out-of-Pocket Maximums. Once the prescription drug Out-of-Pocket Maximums have been met, prescription drugs are covered at 100% coverage for the balance of the Calendar Year. Covered generic and single-source brand name contraceptive medications and devices are covered at 100% coverage Tobacco cessation products are covered at 100% coverage	**Up to a 30 day supply:** **Southcoast Pharmacies** $10 Co-payment per generic^ drug; $30 Co-payment per preferred brand name drug; $75 Co-payment per non-preferred brand name drug. **CVS Caremark Network** $15 Co-payment per generic drug; $50 Co-payment per preferred brand name drug; $100 Co-payment per non-preferred brand name drug. **Up to a 90 day supply:** **Southcoast Pharmacies** $25 Co-payment per generic^ drug; $75 Co-payment per preferred brand name drug; $187.50 Co-payment per non-preferred brand name drug. **CVS Caremark Mail Service** $37.50 Co-payment per generic drug; $125 Co-payment per preferred brand name drug; $250 Co-payment per non-preferred brand name drug. **Specialty Drugs:** **Southcoast Specialty** $50 Co-payment per generic drug; $100 Co-payment per preferred brand name drug; $250 Co-payment per non-preferred brand name drug. **CVS Specialty** $275 Co-payment per generic and brand name drug ^ Generics: some generics are available at a lower cost at Southcoast Pharmacies.
Retail Card/Mail Order Pharmacy Calendar Year Out-of-Pocket Maximums: (Includes all applicable prescription drug Co-payments)	$2,000 per person $4,000 per Employee +1 Up to $4,000 per family
Out-of-Network Pharmacy Coverage	Yes, see CVS Caremark Network above

MEDICAL BENEFITS				
BENEFIT LEVELS	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
Medical Calendar Year Deductible	Single Plan (Employee only): $200 Family Plan (Employee & family): $200 per person $500 per Employee + 1 Up to $500 per family	Single Plan (Employee only): $1,700 Family Plan (Employee & family): $1,700 per person $3,000 per Employee + 1 Up to $3,000 per family	Single Plan (Employee only): $3,200 Family Plan (Employee & family): $3,200 per person $6,500 per Employee + 1 Up to $6,500 per family	Not covered
Note: The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.				
Reimbursement Percentage ("Coinsurance")	100% coverage of the Contracted Rate (after Deductible; unless otherwise stated)	100% coverage of the Contracted Rate (after Deductible; unless otherwise stated)	60% coverage of the Contracted Rate (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)	Not covered, unless otherwise stated. When covered benefit is 60% coverage of the Allowed Amount or the Harvard Pilgrim Health Care Contracted Rate, whichever applies, unless otherwise stated.
Medical Calendar Year Out-of-Pocket Maximums (Including all applicable Co-payments, and the Calendar Year Deductible and Coinsurance)	Single Plan (Employee only): $2,250 Family Plan (Employee & family): $2,250 per person $4,500 per Employee +1 Up to $4,500 per family	Single Plan (Employee only): $4,000 Family Plan (Employee & family): $4,000 per person $8,000 per Employee +1 Up to $8,00 per family	Single Plan (Employee only): $6,150 Family Plan (Employee & family): $6,150 per person $12,300 per Employee +1 Up to $12,300 per family	Not covered
Note: The Family Plan contains both an individual Out-of-Pocket Maximums and a family Out-of-Pocket Maximums. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximums is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximums may be met by any combination of family members.				
IMPORTANT NOTES: Emergency Care, urgent care, ambulance services and limited ancillary charges (i.e. lab, x-rays, anesthesia, etc.) related to these services rendered by an Out-of-Network Provider/facility, are covered under this Plan, subject to the Contracted Rate or Allowed Amount, as applicable. When these services are rendered by a network physician outside of the Covered Person's primary network area, they are covered at the Tier 2 level of benefits under this Plan. All other services rendered by an Out-of-Network Provider outside of the Covered Person's primary network are not covered under this Plan, unless stated otherwise. Primary network for subscribers residing in the 6 New England states and their covered dependents: HPHC Primary network for subscribers residing in the other 44 states and their covered dependents: UnitedHealthcare Please note that other networks may apply. Covered Persons should refer to their ID Cards for the network that applies to them. **The Tiers 1, 2, and 3 Deductible are combined. Eligible expenses which track toward the Tier 1 Deductible will be credited toward the satisfaction of the Tiers 2 and 3 Deductible. The Tiers 1, 2, and 3 Out-of-Pocket Maximums are combined. Eligible expenses which track toward the Tier 1 Out-of-Pocket Maximums will be credited toward the satisfaction of the Tiers 2 and 2 Out-of-Pocket Maximum and vice versa.**				

BENEFIT LEVELS	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
The following expenses are included in the Medical Plan Out-of-Pocket Maximums: • All Co-payments, Deductibles and Coinsurance **The following expenses are excluded from the Medical Out-of-Pocket Maximum(s):** • Precertification penalties • Prescription drug Co-payment (Refer to Prescription Drug Benefit above for separate Prescription Out-of-Pocket Maximums) ***The Covered Person is also responsible to pay any amount above the Allowed Amount when services are rendered by an Out-of-Network Provider.***				
PREVENTIVE CARE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
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 (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Steward Physician charges: 60% coverage (after Tier 3 Deductible) Immunizations and shots: Not covered
****Routine Well Child Care** (Including screenings, routine immunizations and flu shots)	100% coverage (Deductible waived)	$25 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Steward Physician charges: 60% coverage (after Tier 3 Deductible) Immunizations and shots: Not covered
****Fluoride Varnish** (Up to age 6) Up to four (4)* varnish treatments per person, per Calendar Year	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Breastfeeding Support and Counseling** (During pregnancy and/or in the postpartum 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 (Deductible waived) Not available	100% coverage (Deductible waived) 100% coverage (Deductible waived)	60% coverage (after Deductible) 60% coverage (after Deductible)	Not covered

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

PREVENTIVE CARE	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
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.				
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Routine Pap Smears**	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
**** Breast Cancer Screening including Routine Mammograms and BRCA testing** (Age 40 and older)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived) for Breast Cancer Screening including Routine Mammograms 100% coverage (Deductible waived) for BRCA testing	60% coverage (after Deductible)	Not covered
One Baseline Mammogram (Age 35 through 39)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Routine Immunizations** (If not billed with an office visit; includes flu shots)	100% coverage (Deductible waived)	<u>Adult (age 18 and over):</u> $35 Co-payment per visit, then 100% coverage (Deductible waived) <u>Pediatric (to age 18):</u> 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Routine Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

PREVENTIVE CARE	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
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.				
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1)* per person, per Calendar Year	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Nutritional Counseling**	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived) for Smoking Cessation Counseling 100% coverage (Deductible waived) for Smoking Cessation Intervention (including clinics and programs)	60% coverage (after Deductible) for Smoking Cessation Counseling 100% coverage (Deductible waived) for Smoking Cessation Intervention (including clinics and programs)	Not covered
Routine Hearing Exams Up to one (1)* exam per person, per Calendar Year	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings (Age 40 and over) Up to one (1)* exam per person, per Calendar Year	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1)* per person, per lifetime	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
****Bone Density Screening**	100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

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

PREVENTIVE CARE	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
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 Pediatric Dental Care (Up to age 12) Including: • One (1) initial exam per covered child, • One 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)	Not covered
VISION CARE	**TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK**	**TIER 2: PREFERRED PROVIDERS**	**TIER 3: NON-PREFERRED HOSPITALS**	**OUT-OF-NETWORK (TIER 4)**
Routine Vision Exam (Includes contact lens fitting) Up to one (1)* exam per person, per Calendar Year	$35 Co-payment per visit, then 100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	$35 Co-payment per visit, then 100% coverage (Deductible waived)	Not covered
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

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

PHYSICIAN SERVICES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Allergy Testing	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Allergy Treatment	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Anesthesia (Inpatient/Outpatient)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	60% coverage (after Tier 3 Deductible)
Audiology	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Chiropractic Services	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Colonoscopy (Non-Routine)	100% coverage (after Deductible)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Maternity (Includes Physician delivery charges, prenatal and postpartum care)	100% coverage (Deductible waived)	100% coverage (Deductible waived) $40 Co-payment for initial visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Physician Hospital Visits	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	60% coverage (after Tier 3 Deductible) for emergency services provided at a non-Steward facility All other services: Not covered

PHYSICIAN SERVICES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Physician Office Visits – Pediatrician (Includes all related charges billed at time of visit)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$30 Co-payment per visit, then 100% coverage (Deductible waived; *precertification required for oncologist or hematologist*)	60% coverage (after Deductible: *precertification required for oncologist or hematologist)*)	Steward Physician charges: 60% coverage (after Deductible) Related charges, including tests and procedures: Not covered
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived; *precertification required for oncologist or hematologist*)		
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived; *precertification required for oncologist or hematologist*)	60% coverage (after Deductible; *precertification required for oncologist or hematologist*)	Steward Physician charges: 60% coverage (after Deductible) Related charges, including tests and procedures: Not covered
Second or Third Surgical Opinion (Third surgical opinion if second surgical opinion differs from the first opinion)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Surgery (Inpatient; *precertification required)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not Covered
Surgery (Outpatient; *precertification may be required; see Appendix A)*	100% coverage (after Deductible)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Surgery (Physician's office; *precertification may be required; see Appendix A)*	Primary Care Physician: $20 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $30 Co-payment per visit, then 100% coverage (Deductible waived)	Primary Care Physician: $40 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not Covered

HOSPITAL SERVICES – INPATIENT	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty*, unless otherwise noted.* ***Procedures that are not Medically Necessary will not be covered.*** **Oncology Treatment (including Office Visits):** Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**				
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Maternity Services Semi-private room or special care unit	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Birthing Center	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not Covered
Organ, Bone Marrow and Stem Cell Transplants *(Precertification required; see* Medical Benefits *section for other limitations*) Semi-private room or special care unit Includes transportation, food and lodging expenses	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Surgical Facility & Supplies	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered
Miscellaneous Hospital Charges	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not Covered

HOSPITAL SERVICES – OUTPATIENT	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty, unless otherwise noted. Procedures that are not Medically Necessary will not be covered. **Oncology Treatment (including Office Visits):** Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**				
Clinic Services (At a Hospital)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) Co-payment is waived if admitted on an inpatient as an inpatient **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.)	$200 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Deductible)	$200 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Deductible)	$200 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Tier 2 Deductible)	$200 Co-payment per visit, then 100% coverage 100% coverage (after Tier 2 Deductible)
Esophagogastroduodenoscopy (EGD)	100% coverage (after Deductible)	80% coverage *(*after Deductible; *precertification required)*	60% coverage (after Deductible; *precertification required)*	Not covered
Outpatient Department	100% coverage (after Deductible)	80% coverage *(*after Deductible*)*	60% coverage (after Deductible*)*	Not covered
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (*Precertification is required*)	100% coverage (after Deductible)	80% coverage *(*after Deductible*)*	60% coverage (after Deductible*)*	Not covered
Preadmission Testing	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not Covered
Student Health Centers	$40 Co-payment per visit, then 100% coverage (Deductible waived)			
Urgent Care Facility/Walk-In Clinic	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	60% coverage (after Tier 3 Deductible)

MENTAL HEALTH/ SUBSTANCE ABUSE	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Inpatient hospitalizations and certain outpatient procedures require precertification at (877) 234-5550. Failure to precertify may result in a $250 penalty*, unless otherwise noted.* ***Procedures that are not Medically Necessary will not be covered.*** **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.** **Note: A private room is covered only when Medically Necessary or when a facility does not provide semi-private rooms**				
Inpatient Hospitalization *(Precertification required)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	Not Covered
Partial Hospitalization/ Intensive Outpatient Treatment *(Precertification required)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	Not Covered
Inpatient Physician Visit	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	Not Covered
Hospital Clinic Visit	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	Not Covered
Office Visit	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$20 Co-payment per visit, then 100% coverage

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Oncology Treatment (including Office Visits): Oncology treatment (including office visits) by a Tier 2 or 3 provider for patients age 18 years or older must undergo precertification by Conifer Health Solutions. Failure to coordinate oncology treatment or an office visit through Conifer will result in a $500 penalty.				
Ambulance Services (*See* Medical Benefits *section for limitations*)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage
Autism Spectrum Disorders Treatment (Includes Applied Behavioral Analysis (ABA); benefit limits apply to occupational, physical and speech therapies; s*ee* Medical Benefits *section for limitations*) Note: Screenings are covered under Preventive Care	ABA and therapies: $20 Co-payment per visit, then 100% coverage (Deductible waived) All other treatments: Covered according to services provided unless otherwise noted	ABA and therapies: $20 Co-payment per visit, then 100% coverage (Deductible waived) All other treatments: Covered according to services provided unless otherwise noted	ABA and therapies: $20 Co-payment per visit, then 100% coverage (Deductible waived) All other treatments: Covered according to services provided unless otherwise noted	Not covered
Bariatric Surgery (When related to treatment of Morbid Obesity)	100% coverage (after Deductible)	100% coverage (after Deductible; *precertification required)*	60% coverage (after Deductible; *precertification required)*	Not covered
Biofeedback	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Chemotherapy & Radiation Therapy *(Precertification required for chemotherapy)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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 (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services; see Medical Benefits section for other limitations)	Benefits are based on services provided	Benefits are based on services provided	Benefits are based on services provided	Not covered
Cochlear Implants *(Precertification required)*	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	Dentist's Office: 100% coverage (Deductible waived) Outpatient Surgical Facility: 100% coverage (after Deductible)	Dentist's Office: 100% coverage (Deductible waived) Outpatient Surgical Facility: 100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Diabetes Self-Management Training and Education	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Diagnostic X-ray and Laboratory (Outpatient)	100% coverage (Deductible waived)	80% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Durable Medical Equipment *(Precertification required for equipment in excess of $1,500, rentals exceeding three (3) months, TENS units must be precertified; see also* Insulin Pumps*, see* Medical Benefits *section for other limitations)*	Not available	80% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Early Intervention Services (*See* Medical Benefits *section for limitations*) (Up to age 3)	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Erectile Dysfunction Treatment (Limited to treatment of a medical condition or treatment of erectile dysfunction as a consequence of medical treatment)	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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 (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Gender Dysphoria Treatment and Related Services (Includes gender identity counseling, gender reassignment surgery and hormone replacement therapy; *precertification required for gender reassignment surgery; see* Medical Benefits *section for other limitations)*	Benefits are based on services provided	Benefits are based on services provided	Benefits are based on services provided	Not covered
Genetic Counseling	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Genetic Testing and Related Services (Note: Coverage is provided for BRCA Testing – See Breast Cancer Screening in Preventive Care Services; Precertification is not required)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Growth Hormones *(Precertification required; see* Medical Benefits *section for other limitations)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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 (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Hemodialysis	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered, except when approved by Confer due to provider coverage
High Tech Diagnostic Imaging (MRI, CT Scan, PET Scan)	100% coverage (Deductible waived)	80% coverage (after Deductible; *precertification required for MRIs/MRAs, nuclear cardiology services, and PET/CAT scans*)	60% coverage (after Deductible; *precertification required for MRIs/MRAs, nuclear cardiology services, and PET/CAT scans*)	Not covered

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

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Home Health Care *(Precertification required after 8 visits; see* Medical Benefits *section for other limitations)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Hospice Care (Inpatient/Outpatient) *(Precertification required; see* Medical Benefits *section for other limitations)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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)* additional IUI cycles are permitted with an approved treatment plan from Conifer.	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Injectables	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Insulin Pumps	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Learning Deficiencies, Behavioral Problems, and Developmental Delays	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Mastectomy & Reconstruction Surgery	100% coverage (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Medical and Enteral Formula (Including metabolic formula; *see* 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 (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Modified Low Protein Food Products (S*ee* 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 (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

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

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Neuromuscular Stimulator Equipment including TENS *(Precertification required as noted under the Durable Medical Equipment benefit)*	Not available	80% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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 Treatment per person, per Calendar Year	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Other Medical Supplies (Including diabetic supplies, ostomy and colostomy supplies)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Orthotics *(Purchases of $1,500 or more must be precertified)*	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Pain Management Injections Performed in an office or clinic *(Precertification required for occipital nerve block)* Performed in a surgical facility or outpatient department of a hospital *(Precertification required)*	Primary Care Physician: $20 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $30 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Deductible)	Primary Care Physician: $40 Co-payment per visit, then 100% coverage (Deductible waived) Specialist: $50 Co-payment per visit, then 100% coverage (Deductible waived) 100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
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 Treatment per person, per Calendar Year	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Podiatry Care *(See* Medical Benefits *section for limitations*)	$30 Co-payment per visit, then 100% coverage (Deductible waived)	$50 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered

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

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Prosthetics *(Purchases of $1,500 or more must be pre-certified*; see *Medical Benefits* section for other limitations)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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 (after Deductible)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
Respiratory Therapy	100% coverage (Deductible waived)	100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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	Not available	100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered
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 Treatment per person, per Calendar Year	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Telemedicine Southcoast Health On Call at oncall.southcoast.org	$10 Co-payment, then 100% coverage (Deductible waived)	Not covered	Not covered	Not covered
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	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
Voluntary Sterilization **For Women** **For Men**	100% coverage (Deductible waived)	100% coverage (after Deductible)	60% coverage (after Deductible)	Not covered

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

OTHER SERVICES & SUPPLIES	TIER 1: SOUTHCOAST HOSPITALS & PHYSICIANS NETWORK	TIER 2: PREFERRED PROVIDERS	TIER 3: NON-PREFERRED HOSPITALS	OUT-OF-NETWORK (TIER 4)
Voluntary Termination of Pregnancy	$20 Co-payment per visit, then 100% coverage (Deductible waived)	$40 Co-payment per visit, then 100% coverage (Deductible waived)	60% coverage (after Deductible)	Not covered
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*); s*ee* Medical Benefits *section for other limitations*) Up to $500* per person, per Calendar Year	100% coverage (Deductible waived)	100% coverage (Deductible waived)	100% coverage (Deductible waived)	Not covered

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

WELLNESS BENEFITS	ALL PROVIDERS
Childbirth Classes	First childbirth course: 100% coverage up to a maximum of $90 for each covered expectant mother. Refresher childbirth course: 100% coverage up to a maximum of $45 for each covered expectant mother.
Fitness Reimbursement Benefit	100% coverage up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees or qualified yoga classes. (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 or have attended at least four (4) qualified yoga classes and have been on this plan for at least four (4) consecutive months to be eligible for reimbursement.)

Important Notes: Services provided by a Steward Physician in a Tier 1 facility are covered at the Tier 1 benefit level.

V. MEDICAL BENEFITS

A. Benefit Levels

Tier 1 , Tier 2, and Tier 3 Providers

If a Covered Person has incurred covered medical expenses and services are rendered by a Tier 1, 2, or 3 Provider, the Plan will pay the Reimbursement Percentage of the Contracted Rate (after satisfaction of the Calendar Year Deductible) as shown in the Schedule of Medical Benefits. **Benefits for Covered Services outside of Tier 1, 2, and 3 will not be paid, except for childbirth classes, fitness reimbursement, inpatient admission directly from the emergency room, emergency medical care, urgent care, certain covered office visits or hospital visits as described in the Schedule of Medical Benefits, and certain covered ancillary benefits described in the Schedule of Medical Benefits.**

Out-of-Network (Tier 4)

Out-of-Network providers, will be paid at Tier 1, 2 or 3 Provider Co-payment and Coinsurance levels subject to the Contracted Rate or Allowed Amount, as applicable, when covered ancillary medical services are rendered to a Covered Person on an inpatient or outpatient basis in a corresponding Tier 1, 2 or 3 Hospital or facility. Covered 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.

Urgent and "Emergency Care" as defined in the section titled "Definitions", and ambulance services rendered by Out-of- Network providers are covered at the Tier 3 level, subject to the Contracted Rate or Allowed Amount, as applicable. In addition, Tier 3 and Out-of-Network 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. Childbirth classes, fitness reimbursement, inpatient admission directly from the emergency room, and certain covered office visits or hospital visits are covered as shown in the Schedule of Medical Benefits. **All other services rendered by an Out-of-Network provider are not covered under this Plan.**

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 3 Provider levels subject to the Allowed Amount (after satisfaction of the applicable Calendar Year Deductible).

Deductible

With respect to a Covered Person, the Deductible for services rendered by Tier 1, 2 or 3 Providers in each Calendar Year shall be as shown in the Schedule of Medical Benefits. The Family Plan contains both an individual Deductible and a family Deductible. Once an individual family member satisfies the individual Deductible, claims will be paid for that individual. Otherwise, the entire family Deductible must be satisfied before claims will be paid for any family members. The family Deductible may be met by any combination of family members.

The Tiers 1, 2 and 3 Deductibles are combined. Eligible Tier 1 and 2 expenses which track toward the Tier 1 and 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 Services 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

The Out-of-Pocket Maximum includes prescription drug Co-payments. 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 Co-payments; Deductibles; and Co-insurance. The Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount or the Harvard Pilgrim Health Care Contracted Rate, when applicable; prescription drug Co-payments; and any penalties for failure to follow Precertification Requirements.

The Family Plan contains both an individual Out-of-Pocket Maximum and a family Out-of-Pocket Maximum. Once an individual family member satisfies the individual Out-of-Pocket Maximum, claims will be paid for that individual at 100%. Otherwise, once the entire family Out-of-Pocket Maximum is satisfied, claims will be paid at 100% for all covered family members. The family Out-of-Pocket Maximum may be met by any combination of family members.

The Tiers 1, 2, and 3 Out-of-Pocket Maximums are combined. Eligible Tiers 1 and 2 expenses which track toward the Tiers 1 and 2 Out-of-Pocket Maximum will be credited toward satisfaction of Tier 3 Out-of-Pocket Maximum 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 Services

This section contains detailed information on the benefits covered under this Plan. Covered Services must be prescribed by a Physician and incurred for medical treatment of an Illness or Injury. Covered Services may be 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, including U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices, will be covered as described in the section titled "Schedule of Medical Benefits" through Southcoast pharmacy, retail pharmacies and Prescription Benefit Manager'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. Certain prescribed medications (or the prescribed quantity of a

drug) require "prior authorization" before Covered Persons may fill their prescriptions. Some medications require prior authorization as a safeguard to ensure the prescribed medication is safe, medically effective, and the most appropriate way to treat a Covered Person's condition. In some instances, if necessary, a Physician will ask for a clinical review, which will help determine whether the prescribed prescription is approved or denied under the Plan.

Prescription drug charges not covered, including but not limited to:

(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 and tobacco cessation products;

(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.

Note: The following drugs are available through the Prescription Drug Benefit but are excluded from coverage under the Medical Plan unless administered on an inpatient basis, in the emergency room, or at the direction of Conifer or MedImpact; Abatacept (J0129), Adalimumab (J0135), Bivagam (J1556), Botox (J0585), Filgrastim (g-csf) (J1442), Gammaplex (J1557), Gamunex-C (J1561), Enbrel (J1438), Humate-p (J7187), Humira (J0135), Infliximab (J1745), Kogenate FS (J7190), Neothylline (J2390), Neulasta (J2505), Neumega (J2355), Neupogen (J1440), Neupogen (J1441), and Orencia (J0129), Pegfilgrastim (J2505), Privigen (J1459), and Sargramostim (J2820).

(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 https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

(b) **Routine Well Child Care

Routine Well Child Care including all charges billed at the time of visit, including, but not limited to fluoride and fluoride varnish to age 6, physical examinations, history, sensory screening and neuropsychiatric evaluation, and appropriate immunizations. Covered services include, but are not limited to those listed at https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

(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 https://www.healthcare.gov/what-are-my-preventive-care-benefits/.

(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 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

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

(g) **Routine colorectal cancer screening

Includes fecal occult screening, sigmoidoscopy and colonoscopy

(h) ** Lung cancer screening

Includes use of low dose computed tomography (LDCT) for adults age 55 and older who have a 30 pack per year smoking history and currently smoke or have quit within the past 15 years

(i) **Nutritional counseling

(j) **Smoking cessation counseling and intervention

Includes smoking cessation clinics and programs. Tobacco cessation products are available under the Prescription Drug Program.

(k) Routine hearing exam

(l) Routine prostate exam

Includes Prostate-Specific Antigen (PSA) screening

(m) **Abdominal aortic aneurysm screening

(n) **Bone density screening

(o) Pediatric dental care

(3) Vision Care

(a) Routine vision exam including contact lens fittings

(b) Vision eyewear for special conditions:

(i) Non-routine eye wear following surgery, initial purchase (lenses, frames, and contact lenses)

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

(iii) 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 (Inpatient/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 as follows:

(i) For Tiers 1, 2 or 3 Providers: the fee schedule amount for the primary procedure and the greater of 50% of the fee schedule amount or the amount specified in the Provider's contract for the secondary or lesser procedure(s)

(ii) For Out-of-Network (Tier 4) providers otherwise covered: the Allowed Amount for the major procedure and 50% of the Allowed Amount 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.

(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 which are in excess of the Hospital's semiprivate room rate. Charges made by a Hospital for a private room when: i) determined to be Medically Necessary, ii) a semi-private room is not available; or iii) the Hospital only has private rooms will be allowed at the private room rate with no reduction. If a semi-private room is available and the Covered Person chooses a private room, charges for a private room which are in excess of the Hospital's semi-private room rate will be excluded or, if the semi-private rate is not available, reduced by 20%

(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 Conifer.

(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

Transplant Benefit Period: Covered transplant expenses will accumulate during a Transplant Benefit Period and will be charged toward the Transplant Benefit Period maximums, if any, shown in the Schedule of Medical Benefits. The term "Transplant Benefit Period" means the period which begins on the date of the initial evaluation and ends on the date

which is twelve (12) consecutive months following the date of the transplant. If the transplant is a bone marrow transplant, the date the marrow is reinfused is considered the date of the transplant.

Covered transplant expenses: Covered Services 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. The harvesting of the marrow need not be performed within the Transplant Benefit Period.

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.

Re-transplantation: Re-transplantation will be covered up to two (2) re-transplants, for a total of three (3) transplants per person, per lifetime. Each transplant and re-transplant will have a new Transplant Benefit Period.

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

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

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

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

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

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

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

(d) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist; or

(g) Psychiatrist.

(10) Other Services and Supplies

(a) Ambulance services:

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

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

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

(b) 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 Applied Behavior Analysis (ABA), occupational, physical and speech therapies, and social work services

(c) Bariatric surgery for the treatment of Morbid Obesity

(d) Biofeedback

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

(f) 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.

(g) Chemotherapy and radiation therapy

(h) 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.

(i) 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.

(j) Cochlear implants

(k) 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.

(l) Diabetes self-management training and education

(m) 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

(n) 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, CPAP machines, 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

(o) 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.

(p) Erectile dysfunction treatment

(q) Family planning services including consultations and diagnostic tests

(r) Gender dysphoria treatment, including but not limited to, gender reassignment surgery, counseling and hormone treatment (as covered under the Prescription Drug benefit)

(s) Genetic counseling, testing and related services

See Preventive Care Service for BRCA testing

(t) Growth hormones

Growth hormones when prescribed by a board certified pediatric endocrinologist and a written treatment plan is submitted for approval to Conifer. 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.

(u) 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.

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

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

(x) Home health care

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

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

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

(iii) Services provided by home health aides; and

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

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

(y) 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.

(z) 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) additional IUI cycles are permitted with an approved treatment plan from Conifer.

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)

Includes retrieval, cryopreservation, and storage (up to one year) of sperm or eggs when documentation confirms an eligible Covered Person with gender dysphoria/gender incongruence will be undergoing gender reassignment treatment that is likely to result in infertility.

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

(bb) Learning deficiencies, behavioral problems/developmental delays

(cc) 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.)

(dd) 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.

(ee) 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.

(ff) 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.

(gg) 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

(hh) Orthoptics

Treatment and services rendered by a certified orthoptist whose primary purpose is to diagnose and provide non-surgical management of certain eye movement disorders, such as strabismus, amblyopia, exotropia and/or esotropia in an outpatient setting, including a freestanding duly licensed outpatient therapy facility

(ii) Orthotics

For the purpose of treating an Illness or Injury, services and equipment such as 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

(jj) Oxygen and other gasses and their administration

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

(ll) Physical Therapy

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

(mm) 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

(nn) 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 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.

(oo) 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

(pp) 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

(qq) 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

(rr) Sleep disorders

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

(ss) 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.

(tt) Telemedicine services

Medically Necessary telemedicine services for the purpose of diagnosis, consultation or treatment in the same manner as an in-person consultation between the Covered Person and the Provider. Telemedicine services are limited to the use of real-time interactive audio, video, or other electronic media telecommunications as a substitute for in-person consultation with Providers.

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

(vv) Voluntary sterilization

(ww) Voluntary termination of pregnancy

(xx) 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 or qualified yoga classes up to a total reimbursement of $150 per family, per Calendar Year. Membership or class 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 or have attended at least four (4) qualified yoga classes 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 Services 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, 2 or 3 Providers, or, if not Tier 1, 2, or 3 but otherwise covered, in excess of the Allowed Amount or the HPHC fee schedule, whichever applies, for Out-of-Network (Tier 4) 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. This exclusion does not apply to (a) Injuries sustained by a Covered Person who is a victim of domestic violence or (b) Injuries resulting from a medical condition (including both physical and mental health conditions)

(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) Acupuncture therapy

(19) Chelation therapy

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

(21) 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."

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

(23) Fluoride and fluoride varnish, for Covered Persons age 6 and over

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

(25) Gender dysphoria/gender incongruence treatment excludes the following services: abdominoplasty, collagen injections, dermabrasion, chemical peels, electrolysis, hair removal, or hair transplantation (except when required pre-operatively for genital surgery), gender reversal surgery and all related drugs and procedures related to the reversal, hair transplantation, implantations (e.g. calf, pectoral, gluteal), lip reduction/enhancement, liposuction, panniculectomy, removal of redundant skin, silicone

injections (e.g., for breast enlargement), voice modification therapy/surgery, and reimbursement for travel expenses.

(26) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, 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) Massage therapy

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

(32) Methadone maintenance and treatment

(33) Naturopathic medicine

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

(35) Pain clinic and pain management registration and program fees

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

(37) 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

(38) Planned home births

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

(40) Private duty nursing

(41) Sex therapy

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

(43) Visual refraction surgery, including radial keratotomy

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

(45) Weight loss programs, except when provided by Southcoast Hospital

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

Some of the terms used in this Article have special meanings under the Plan. These terms will always begin with capital letters. Please refer to the Article titled Definitions for an explanation of these terms.

A. Eligibility

Benefit eligible Employees, and their Eligible Dependents, are initially eligible to participate in the Plan on the first day of the month following or coinciding with 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:
(a) Initial Eligibility Period	Thirty (30) days from the date of benefit eligibility
(b). Open Enrollment Period	The last day of the annual enrollment period specified by the Plan Administrator
(c) Qualified Change in Status	Thirty (30) days after the date of the Qualifying Change in Status*
(d) 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
(e) HIPAA Special Enrollment Period i. Following loss of other coverage or ii. Acquisition of Eligible Dependent	Thirty (30) days after the date of the loss of other coverage*

*In the case of an adopted child, this means the date the child is placed with the Employee for adoption.

(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 an enrollment periods described 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 elections 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 an 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, 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 or other Eligible Dependent;
- A child's loss or gain of Eligible Dependent status;
- An Employee'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 or Spouse's employer-provided health care coverage;
- A Spouse's employer's open enrollment period during which the Spouse changes his or her election regarding health care coverage;
- A change in employment status for the Employee or Spouse, with corresponding changes in eligibility for coverage under either employer's plan;
- A reduction in an Employee's hours to fewer than 30 per week without regard to whether the change causes a loss of eligibility under this Plan if the Employee intends to enroll in another plan that provides Minimum Essential Coverage (MEC) as defined under the Affordable Care Act;
- An Employee's intention to enroll in a Qualified Health Plan through a Health Insurance Marketplace ("Marketplace") due to eligibility for a Special Enrollment Period (e.g., marriage, birth of child), where the Employee revokes coverage under this Plan, provided coverage under the Qualified Health Plan begins on the day immediately following the loss of coverage under this Plan;
- A Spouse 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 qualifying change in family or employment 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 qualifying change in family or employment status, within thirty (30) days of the applicable 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) HIPAA Special Enrollment Period Following Involuntary Loss of Other Coverage or Acquisition of Eligible Dependent

(i) Enrollment 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:

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

b. The Employee signed a written waiver of coverage under this Plan whenever such coverage was offered, giving the existence of alternative health coverage as the reason for waiving the coverage, on forms furnished by and delivered to the Plan Administrator within the specified enrollment period each time such coverage was offered;

c. 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.

d. 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.

(ii) Enrollment following acquisition of Eligible Dependents

If an Employee is not covered under this Plan, but meets the eligibility requirements, the Employee may be eligible to enroll and may be eligible to enroll any Eligible Dependents if all the conditions below are met:

a. Another individual (a Spouse or child) has become an Eligible Dependent of the Employee through marriage, birth, adoption, or placement for adoption; and

b. The Employee submits a completed enrollment form to the Plan Administrator, with written documentation of the acquisition of the new dependent, within thirty (30) days of the marriage, birth, adoption, or placement for adoption.

(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 except as follows: ▪ Coverage revoked due to a reduction in hours ends on the date specified by the Employee, but no earlier than the date the revocation is received by the Plan Administrator, and no later than the last day of the month following the month the coverage was revoked	
4. Special Enrollment Period: Gain or loss of eligibility for Medicaid or CHIP	Begins or ends, as applicable, on the date of the loss or gain of eligibility for Medicaid or CHIP	
5a. HIPAA Special Enrollment Period: Loss of other coverage	Begins on date of loss of coverage	
5b. Special Enrollment Period: Acquisition of Eligible Dependent	Begins or ends, as applicable, on date of acquisition of Eligible Dependent*	

*In the case of adoption, this means the date the child is placed for adoption.

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

(i) Leave of Absence under FMLA

A covered 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 any covered dependents, may continue to participate in this Plan until the earliest of:

a. The expiration of the leave, or

b. 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.

(2) Leave of Absence for Military Service

A covered Employee who is absent from work due to military service and any covered dependents may continue to participate in this Plan for up to 24 months provided the Employee continues to make any required contributions.

(3) 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 (other than under FMLA)**

A covered 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 (other than under FMLA)**

A covered Employee who is absent from work on a full-time basis due to an approved medical leave of absence, (other than under FMLA), 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.

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 accumulate 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 Return to Work or Reemployment

(i) Return from FMLA Leave

Participation in the Plan will begin immediately for any Covered Person who discontinued coverage during a leave of absence taken under the FMLA by the Employee, provided the Employee returns to Actively at Work status before or immediately following the expiration of the FMLA leave, and provided that the Employee is eligible for coverage upon return in accordance with the provisions of Section A of this Article, Eligibility.

(ii) Return from Military Service

Participation in the Plan will begin immediately for an Employee absent from work due to military service, and for dependents covered under the Plan when the military service began, 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 is eligible for coverage upon return in accordance with the provisions of Section A of this

Article, Eligibility, and 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.

(iii) Return from Disability or other Approved Leave of Absence (other than FMLA or Military Service Leave)

Participation in the Plan will begin immediately for an Employee and any dependents whose coverage was discontinued during a period of disability or other approved leave of absence, provided the Employee returns to Actively at Work status immediately upon the expiration of the approved leave, or upon no longer being Totally Disabled (if earlier), and provided that the Employee is eligible for coverage in accordance with the provisions of Section A of this Article, Eligibility.

(iv) Reemployment While Covered under COBRA

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 provided the Employee is eligible for coverage in accordance with the provisions of Section A of this Article, Eligibility.

(v) Reemployment in General

The provisions below apply to former Employees and their dependents who were covered under the Plan on the date the Employee terminated employment and who do not fall into the categories described in (i) through (iv) above.

a. A rehired Employee who was a participant in the Plan on the date of employment termination may resume participation in the Plan on the first day of continuous employment if the Employee has not had a Break-in-Service greater than the period as defined under this Plan.

b. In the case of a reemployed Employee eligible to participate under the conditions stated under (i) above, but who had not satisfied the Waiting Period as of the termination date, the Waiting Period will be reduced by the period of prior employment and the period between the date of termination and date of rehire.

c. In cases of reemployment following a Break-in-Service, eligibility to participate will be based on the Employee's status on the date of rehire in accordance with the provisions of Section A of this Article, Eligibility, as they relate to new hires.

(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 §1862(b) (42 U.S.C. §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.

<u>For Former Employees Who Participate in the Southcoast Voluntary Separation Incentive Plan</u>:

Benefits for **Covered Services incurred during the first year following termination of employment:** If the former Employee or his/her covered dependents are eligible for Medicare (other than ESRD), benefits will not be offset by amounts that would be

payable under Medicare Parts A and B if the Covered Person did not apply for entitlement to Medicare Part A or Part B or applied for entitlement to Part A and/or Part B, but did not choose to elect Part B.

Benefits for **Covered Services incurred after the initial year following termination of employment:** If the former Employee or his/her covered dependents are eligible for Medicare (other than ESRD), benefits will be determined in accordance with Medicare secondary payor rules and on an assumptive basis, whereby benefits will be calculated as if Medicare provided reimbursement for the expenses being claimed, as outlined in the first two (2) paragraphs above.

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, a Covered Person may be required to provide confirmation regarding any other health coverage the Covered Person may have and must furnish information regarding such coverage as may be necessary to implement this provision. Until confirmation regarding any other coverage is provided, payment of the Covered Person's claims under the Plan may be delayed and claims may be denied if confirmation is not received. In addition, 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.

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 consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Directors to replace any or all of the members of the committee, or to eliminate the committee entirely.

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

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

E. Indemnification and Exculpation

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

F. Compensation of Plan Administrator

Unless otherwise agreed to by the Board of Directors, the Plan Administrator will serve without compensation for services rendered in such capacity, but all reasonable expenses

incurred in the performance of the Plan Administrator's duties will be paid by the Employer.

G. Bonding

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

H. Payment of Administrative Expenses

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

X. TERMINATION 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 last day of the month in which the Employee terminates employment.

(b) The last day of the month in which the Employee ceases to be in a class of eligible Employees as described in the *Eligibility, Enrollment and Participation* section in this document.

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

(d) The last day of the month in which the Employer terminates the Employee's coverage.

(e) The day this Plan terminates.

(f) The last day of the month in which 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 first 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:

(a) The last day of the month in which an Employee's child turns age 26;

(b) The last day of the month in which the dependent no longer satisfies the definition of an Eligible Dependent; or

(c) The first 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 last day of the month in which the Pre-Age 65 Retiree reaches age 65.

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

(c) The last day of the month in which the Employer terminates the Pre-Age 65 Retiree's coverage.

(d) The day this Plan terminates.

(e) The last day of the month in which 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. 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" or "COBRA coverage."

COBRA 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 or Pre-Age 65 Retirees who have not experienced a Qualifying Event (in other words, similarly situated non-COBRA beneficiaries).

When a covered Employee and the Employee's covered dependents become eligible for COBRA, they may also become eligible for other coverage options that may cost less than COBRA continuation coverage. For example, a covered Employee and the Employee's covered dependents may be eligible to enroll through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a Spouse's plan) through what is called a "special enrollment period." By enrolling in these other coverage options, an Employee may qualify for lower costs on monthly premiums and/or lower out-of-pocket costs.

Additional information about many of these options can be found at www.healthcare.gov.

(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. 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) The Spouse or Eligible Dependent child of a covered Employee who, on the day before a Qualifying Event, is covered under the Plan.

(c) Any child who is born to or placed for adoption with a covered Employee during a period of COBRA continuation coverage.

(d) A covered Employee who retired on or before the date of substantial elimination of Plan coverage which is the result of a bankruptcy proceeding under Title 11 of the U.S. Code with respect to the Employer, as is the Spouse, surviving Spouse or Eligible Dependent child of such a covered Employee if, on the day before the bankruptcy Qualifying Event, the Spouse, surviving Spouse or Eligible Dependent child was a beneficiary under the Plan.

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 or Pre-Age 65 Retiree.

(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 of a covered Employee from the Employee's Spouse.

(d) A covered Employee's or Pre-Age 65 Retiree's entitlement to Medicare, unless Medicare eligibility is due to End Stage Renal Disease (ESRD).

(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 the Plan Sponsor which results in a loss of coverage for a Pre-Age 65 Retiree.

If the Qualifying Event causes the covered Employee or Pre-Age 65 Retiree, 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.

A voluntary waiver of coverage by an Employee or Pre-Age 65 Retiree on behalf of the Employee or Pre-Age 65 Retiree or an Eligible Dependent, such as during an open enrollment period, is not a Qualifying Event.

(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 Pre-Age 65 Retiree 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 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, during the election period, a Qualified Beneficiary waives COBRA continuation coverage, 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. However, if a waiver is revoked, coverage need not be provided retroactively (that is, from the date of the loss of coverage until the waiver is revoked). 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 or Pre-Age 65 Retiree who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Employee's or Pre-Age 65 Retiree'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 or Pre-Age 65 Retiree 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. The maximum coverage period for a Qualified Beneficiary who is the Spouse, surviving Spouse or Eligible Dependent child of the retired covered Employee ends on the earlier of the date of the Qualified Beneficiary's death or the date that is 36 months after the death of the retired covered Employee.

(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 an Employee experiences a second Qualifying Event while receiving 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 to the Spouse and any Eligible Dependent children receiving continuation coverage if the Employee or former Employee dies, or gets divorced or legally separated, or if the Eligible Dependent child stops being eligible under the Plan as an Eligible Dependent child, but 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

For any period of COBRA continuation coverage, the Plan requires the payment of an amount that equals 102% of the applicable premium, unless the Plan requires the payment of an amount that equals 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 COBRA coverage means payment that is made to the Plan by 30 days after the first day of that 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) COBRA Coverage for Employees in the Uniformed Services

For purposes of this Article, 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 B, item 1 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

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") is a federal law that governs the use and disclosure of protected health information ("PHI") by group health plans and provides rights to Covered Persons with respect to their PHI.

There are three (3) circumstances under which the Plan may disclose a Covered Person's PHI to the Plan Sponsor.

First, the Plan may inform the Plan Sponsor whether a Covered Person 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 experienced by Covered Persons and may identify the Covered Person.

Third, the Plan may disclose PHI 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.

In order for the Plan Sponsor to receive and use PHI, the Plan Sponsor has certified to the Plan that the Plan Sponsor agrees to:

(1) Only use or disclose PHI for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. A description of how the Plan uses and discloses PHI and Covered Persons rights under HIPAA are described in the Plan's Notice of Privacy Practices. The Notice of Privacy Practices is provided upon enrollment and periodically thereafter in accordance with applicable requirements; it can be accessed any time at https://www.healthplansinc.com/members/;

(2) Ensure that any agents, including subcontractors, to whom it provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information;

(3) Not use or disclose PHI for employment-related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor;

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

(5) Make PHI available to a Covered Person in accordance with HIPAA;

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

(7) Make available the information required to provide an accounting of disclosures in accordance with HIPAA;

(8) Make its internal practices, books, and records, relating to the use and disclosure of PHI available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining the Plan's compliance with HIPAA;

(9) If feasible, return or destroy all PHI received from or on behalf of the Plan that Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed to administer the Plan. If return or destruction is not feasible, the Plan Sponsor will limit further use or disclosure to those purposes that make return or destruction of the information infeasible;

(10) Ensure there is adequate separation between the Plan and the Plan Sponsor, as required by HIPAA (45 C.F.R. §164.504(f)(2)(iii)) and described below, and that such separation is supported by reasonable and appropriate security measures:

(a) In addition to the Privacy Officer, the following Employee(s) or class(es) of Employees or other persons under the control of the Plan Sponsor ("Workforce Members") may be given access to PHI, to the extent that such access and use is restricted to plan administration functions that the Plan Sponsor performs for and on behalf of the Plan:

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

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

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

(b) If the Plan Sponsor becomes aware of any Employee or Workforce Member's use or disclosure of PHI in violation of HIPAA or this Summary Plan Description, the Plan Sponsor will promptly report the violation to the Plan and will cooperate with the Plan to address the violation, to impose appropriate sanctions, and to mitigate any harmful effects to a Covered Person.

(11) Implement appropriate and reasonable safeguards (administrative, physical and technical) to protect the confidentiality, integrity and availability of the information it creates, receives, maintains or transmits;

(12) Require that any agent or subcontractor to whom it provides PHI agrees to implement reasonable and appropriate security measures to protect the information;

(13) Report to the Plan any security incident that the Plan Sponsor becomes aware of; and

(14) Maintain adequate separation between the Plan and itself.

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

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

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

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

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

B. Subrogation

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

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

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

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

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

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

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

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

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

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

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

C. Right of Reimbursement

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

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

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

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

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

D. Covered Person is a Trustee Over Plan Assets

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

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

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

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

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

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

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

E. Excess Insurance

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

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

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

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

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

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

F. Separation of Funds

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

G. Wrongful Death

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

H. Obligations

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

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

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

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

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

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

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

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

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

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

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

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

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

I. Offset

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

J. Minor Status

(1) In the event the Covered Person(s) is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.

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

K. Language Interpretation

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

L. Severability

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

XIII. AMENDMENT AND TERMINATION OF PLAN

A. Amendment

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

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

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

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

B. Termination of Plan

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

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

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

XIV. GENERAL PROVISIONS

A. Company Funding

All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No 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 the Employee or the pre-Age 65 Retiree or the Employee's Eligible Dependent under this Plan are not subject to the claim of their creditors and may not be voluntarily or involuntarily transferred, alienated, assigned or encumbered without the written consent of the Plan Administrator.

G. Severability

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

H. Headings

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

I. Applicable Law

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

J. Limitations on Actions

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

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

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

Designating an Authorized Representative

For initial claims
For the purposes of filing initial claims for coverage under the Plan, the health care provider who rendered services to the Covered Person is deemed to be an authorized representative, and most claims are filed by health care providers directly with the Claim Administrator. The Covered Person may also designate another person to be the authorized representative for filing claims by completing the applicable section of the Member Reimbursement form. The Member Reimbursement form can be completed online at the Plan web site shown on the Plan ID card; downloaded and printed; or requested from 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. Claims are subject to the filing limits described in this Article.

For appeals or requests for external review
For the purposes of filing appeals or requesting external review of denied Urgent Care Claims (defined below) on behalf of a Covered Person, the Covered Person's treating health care provider is deemed to be an authorized representative. The Covered Person may also name another individual as an authorized representative for appeals and external review by completing and submitting a Designation of Personal Representative Authorized for Claim Appeal and/or External Review Request form (DPR form), available upon request from the Claim Administrator. For a health care provider to appeal or request review of a non-Urgent Care Claim on behalf of the Covered Person, the Covered Person must execute a DPR form naming the provider as the authorized representative. After an authorized representative has been designated, all subsequent notices and decisions concerning appeals or requests for external review will be provided to the Covered Person through his or her authorized representative.

Exhaustion of Internal Appeals Required

Under this Plan, there are two levels of mandatory internal appeals. A Covered Person is required to exhaust both levels of the internal appeals process before requesting an external review or pursuing other legal remedies that may be available except in the following situations: 1. In cases involving Urgent Care Claims, the Covered Person may forego the internal appeals process and request an expedited external review upon receipt of the initial claim denial and 2. In cases where the Plan has not adhered to the claims and appeals requirements specified in this Plan and the violation is more than *de minimis*, the internal review process may be deemed to be exhausted and the Covered Person may initiate an external review or take other available legal action. Appeals, requests for external review and other legal actions are subject to the filing

periods described in this Article and the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

Claims and Appeals Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to Conifer and the Claim Administrator. As directed by the Plan Administrator, Conifer makes initial claim and initial appeal determinations of Medical Necessity, or for prescription claims the Prescription Benefit Manager, 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 (as defined in the Article titled "Definitions" of this Summary Plan Description).

(2) As directed by the Plan Administrator, initial determinations about benefits payable based on the specific terms of the Plan are made by Conifer for claims that require precertification of Medical Necessity, or for prescription claims the Prescription Benefit Manager, 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, it is called an 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. If the Covered Person disputes the determination, he or she may confirm that the claim was properly processed by contacting Conifer regarding claims denied based on a lack of Medical Necessity, or for prescription claims the Prescription Benefit Manager, 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). Note that in cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the internal appeals process and request an expedited external review *(see 6 below)*.

(4) As directed by the Plan Administrator, any internal appeal filed will be reviewed by Conifer regarding claims denied due to a lack of Medical Necessity, or for prescription claims the Prescription Benefit Manager, 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 with the Claim Administrator, or for prescription claims the Prescription Benefit Manager, within the time periods specified in Chart B, below. In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may forego the second internal appeal and request an expedited external review (see 6 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 required (except as described under *Exhaustion of Internal Appeals Required* above) and 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, or if the initial denial was for an Urgent Care Claim, 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. The Covered Person may also elect to take legal action as may be available under § 502(a) of ERISA or under other state or federal law instead of or following external review, provided such action is initiated within the time period described under the *General Provisions/Limitations on Actions* section of this Summary Plan Description.

A. Who May File a Claim

A Covered Person's health care service provider may submit claims, and most claims are submitted by providers directly to the Claim Administrator. Alternatively, a claim may be filed by a Covered Person, or by his or her authorized representative. See *Designating an Authorized Representative*, above. 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.

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 allowed or making non-Urgent Care Claim 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 Covered Person 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 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 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

An initial claim for inpatient benefits must be submitted by the Covered Person, or by the Covered Person's health care provider or other authorized representative, no later than one (1) year after the discharge date or the date coverage under this Plan ends, whichever occurs first. For outpatient benefits, claims must be submitted no later than one (1) year after the date that services are provided. Claims received after that date will be denied. This time limit does not apply if the Covered Person is legally incapacitated.

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

(1) Urgent Care Claims , including Urgent Concurrent Care Claims:

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

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

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

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

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

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

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

D. Initial Claim Determination

After a claim has been submitted to Conifer or the Claim Administrator, the Plan will make a determination within specified time limits, depending on the type of claim. In some cases, the time limits may be extended if there are circumstances beyond Conifer's or the Claim Administrator's control that require a delay, or if the claim was submitted improperly or lacked information necessary to make a determination. In such cases, the Covered Person 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 Covered Person of improperly filed claim or missing information**	**Period for Covered Person 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*
NON-URGENT CONCURRENT AND PRE-SERVICE 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.
**Provided 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 Covered Person may file an internal appeal of the adverse benefit determination. In making an appeal or request for external review, the Covered Person has the right to designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review. See *Designating an Authorized Representative* at the beginning of this section.

Before filing an appeal, a Covered Person may first want to contact the Claim Administrator at (877) 234-5550, or for prescription claims the Prescription Benefit Manager, 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, or in cases involving Urgent Care, may be filed upon receipt of the initial claim 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) can be filed depends on the type of appeal or request for external review:

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

(a) Urgent Care Claim appeals or requests for external review related to claims denied due to lack of Medical Necessity may be submitted either verbally by calling Conifer at (877) 234-5550 or by any method available for non-urgent and post-service appeals or verbally by calling the Prescription Benefit Manager for prescription claims. Upon request, Urgent Care Claim denials based on a medical judgment may be submitted for external review either upon receipt of the initial claim denial, after the first internal appeal or after completing the internal appeals process.

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

(2) Non-Urgent Care, Pre-Service and Post-Service Care Claim appeals or requests for external review: Call the Prescription Benefit Manager for prescription appeals as shown below.

(a) Non-Urgent Care, Pre-Service and Post-Service Claim appeals or requests for external review of claims denied due to lack of Medical Necessity must be in writing and must be submitted to Conifer using one of the following methods:

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

Medical Appeals	
Clinical Appeals: **Physical and Mailing Address:** Conifer Value-Based Care, LLC 1596 Whitehall Road Annapolis, MD 21409	**Physical Address:** Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 **Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581
Prescription Inquiries/Prior Authorization/Appeals	
Covered Persons should contact the Prescription Benefit Manager direct at the telephone number listed on his/her ID card for directions on submitting appeals.	

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

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

Physical Address:	**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 the 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 Covered Person 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 Covered Person 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 Covered Person will have 60 days to request a second appeal. Alternatively, in cases involving Urgent Care Claim denials based on medical

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

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

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

CHART B Time Limits Regarding Initial and Second Internal Appeals and Request for External Review						
Type of Claim	**Maximum period for Covered Person to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Covered Person 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 Covered Person to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	For denials involving medical judgment, Covered Persons may request expedited external review upon the initial claim denial, upon the first appeal denial, or may request external review within 4 months of the final internal appeal determination	72 hours
NON-URGENT CONCURRENT CARE AND PRE-SERVICE 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; and

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

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

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

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

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

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-beyond 8 visits
- ABA Therapy
- Growth hormone treatment
- Vein therapy
- Pain treatment
- 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

MATERNITY

- Inpatient admission that exceeds 48 hours for a vaginal delivery or 96 hours for a cesarean delivery

SAME-DAY SURGERIES, including the following:

- Cochlear implant
- Cosmetic/reconstructive surgery
- Outpatient transplants
- 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

HOSPICE

- Inpatient or outpatient