hpi | Health Plans, Inc.

Plan Summary

Boston Medical Center

Employee Group Medical Plan (BMC Select)

Effective: January 1, 2018

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #10 TO THE
JANUARY 1, 2018 PLAN SUMMARY
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 require precertification and include 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 change certain PCP and Specialist office visit Co-payments; reduce the age limit for Routine Colorectal Cancer Screening; change Outpatient Surgery (Hospital/Ambulatory Surgical Center) benefit to include a precertification requirement for spine surgeries, joint replacement surgeries and spine injections; remove dollar limits from Early Intervention Services benefit; and update Fitness benefit to include fees for ongoing fitness memberships to gyms, studios, or virtual/online fitness programs. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary 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.

SECTION IV, SCHEDULE OF MEDICAL BENEFITS:

- **Routine Colorectal Cancer Screening** benefit is hereby **deleted** and **replaced** in its entirety with the following;
- **Primary Care Physician** and **Specialist Office Visit Co-payments** are hereby **deleted** and **replaced** in their entirety with the following;
- **Office Visit Co-payments** for certain benefits below are hereby **deleted** and **replaced** in their entirety with the following;
- **Outpatient Surgery in Hospital/Ambulatory Surgical Center** benefit is hereby **deleted** and **replaced** in their entirety with the following;
- **Early Intervention, Orthotics and Fitness Reimbursement** benefits are hereby **deleted** and **replaced** in their entirety with the following in order to provide coverage at the levels shown below:

PREVENTIVE CARE	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
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 45 and older)	100%	Not Covered

VISION CARE	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Routine Vision Exam (Includes contact lens fitting) Up to one* (1) exam per person, per Calendar Year	$7 Co-payment per visit, then 100%	$7 Co-payment per visit, then 100% Allowed Amount
Orthoptics/Vision Therapy	$7 Co-payment per visit, then 100%	Not Covered

***These maximums are combined In-Network and Out-of-Network maximums.**

PHYSICIAN SERVICES	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$7 Co-payment per visit, then 100%	Not Covered
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$7 Co-payment per visit, then 100%	Not Covered
Second Surgical Opinion	$7 Co-payment per visit, then 100%	Not Covered
Surgery (Physician's office)	$7 Co-payment per visit, then 100%	Not Covered

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for all outpatient spine surgeries, joint replacement surgeries and spine injections. **Failure to obtain precertification will result in a reduction in benefits in the amount of $500 per admission.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan. **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)	$7 Co-payment per visit, then 100%	Not Covered
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc. (Precertification required for all spine surgeries, joint replacement surgeries and spine injections)	100%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	Office visit: $7 Co-payment per office visit, then 100% All Other: 100%	Not Covered
Early Intervention Services (*See* Medical Benefits *section for other limitations*) (Up to age 3)	100%	Not Covered
Infertility Treatment *(Precertification required; see Medical Benefits section for other limitations)* Assisted reproductive technologies include, but are not limited to: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$7 Co-payment per office visit, then 100% 100%	Not Covered Not Covered
Orthotics (Includes foot orthotics; *precertification required; see* Medical Benefits *section for other limitations*)	80%	Not Covered
Podiatry Care *(See* Medical Benefits *section for limitations*)	$7 Co-payment per office visit, then 100%	Not Covered

WELLNESS BENEFITS	ALL PROVIDERS
Fitness Reimbursement Benefit	100% up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees, including fees for ongoing fitness memberships to gyms, studios, or virtual/online fitness programs. (Claims must be submitted by March 31st for reimbursement for the prior year. The paid date must be within your dates of enrollment in this Plan.)

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:

  In-Network BMC, HealthNet, Community Health Center and BMC Affiliated Providers – If a Covered Person has incurred Covered Services rendered by a Tier 1 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, student health center 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.

  No Surprises Billing for Out-of-Network Providers - 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 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.

  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-Area Dependent Coverage (for Covered Dependents ages 19 through 25):
  If there is no In-Network Provider, or no In-Network Provider is able to provide the necessary service(s) to the Covered Dependent within a 100-mile radius of the Covered Dependent's residence, then Out-of-Network charges will be covered as In-Network charges (subject to Allowed Amount) when the Covered Dependent provides appropriate documentation.

  All the rules and limits for coverage listed in this document and in the Schedule of Medical Benefits apply to Covered Services for Eligible Dependents when receiving medical services from a network provider outside of the 100-mile radius. **If an Eligible Dependent chooses 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.**

  Important Notice: An Eligible Dependent residing outside of the 100-mile radius must be registered with Health Plans, Inc. to make use of this benefit. Eligible Dependents must complete an *Out-of-Area Dependent Coverage* form and submit to Health Plans, Inc. during the annual Open Enrollment period or within 30 days of moving outside of the 100-mile radius. ***Each Eligible Dependent must re-verify their out-of-area dependent status annually thereafter.*** To obtain a copy of this form, please refer to Health Plans, Inc.'s internet site at https://www.hpiTPA.com/bmc or call the Health Plans, Inc. Customer Service Department at **(844) 926-2262**.

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 In-Network Provider levels subject to the Allowed Amount or Qualifying Payment Amount, as applicable (after satisfaction of the 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 right to continuation of care, if so elected, for a period ending 90 days later or when the Covered Person ceases to be a continuing care patient, whichever is sooner.

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; (h) Surgery (Inpatient/Outpatient/Office)** is hereby **deleted** and **replaced** in its entirety with the following:

  (h) 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 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 (who are not in the network but otherwise covered, such as emergency medical care and urgent care received outside the service area): the Allowed Amount 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.

- **(10) Other Services and Supplies; Orthotics** is hereby **deleted** and **replaced** in its entirety with the following:

  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

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

SECTION XV, 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.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #9 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: SEPTEMBER 1, 2021

This Plan is amended to change cost sharing for 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 Plan Summary is hereby amended as follows:

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

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*)	$5 Co-payment per visit, then 100%	Not Covered
All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	Paid based on services provided	Not Covered

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #8 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JUNE 1, 2021

This Plan is amended to assign the Claim Administrator as claims fiduciary for purposes of initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IX, PLAN ADMINISTRATION, is hereby **deleted** and **replaced** in its entirety with the following:

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, the Board of Directors of the Employer, the Claim Administrator, or the PACE (each a "Delegate" and collectively the "Delegates"), 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 Delegates 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. Notwithstanding the foregoing, the Plan Administrator has delegated to the Claim Administrator discretion, control, and exclusive duty and authority to determine what constitutes a covered benefit under the Plan for claims payments or denials pertaining to initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims, as in accordance with the terms and provisions set forth under Article XV of this Plan entitled "Claims and Appeals Procedures and Statement of Rights." Notwithstanding the foregoing, the Plan Administrator has delegated to the PACE discretion, control and exclusive duty and authority to determine what constitutes a covered benefit under the Plan for claims payment or denials pertaining to second level internal appeal determination for post-service claims as in accordance with the terms and provisions set forth under Article XV of this Plan entitled "Claims and Appeals Procedures and Statement of Rights."

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan, or to delegate such responsibility to the Claim Administrator regarding initial claim determinations, first level internal appeal determination for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims, and to PACE regarding second level internal appeal determination for post-service claims under the Plan.

All determinations of the Plan Administrator or its Delegates, as applicable, 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 the 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 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, or to delegate such responsibility to its Delegates as set forth above, to inform the Employer, as appropriate, of the amount of such Benefits, and to provide a full and fair review to any Covered Person whose claim for benefits has been denied in whole or in part; and

(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

When the Plan Administrator assigns the Claim Administrator the task of making a determination regarding initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims, the Claim Administrator shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator only insofar as it relates to said initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims. Assignment is achieved by and when the Plan Administrator advances a request for a second level internal appeal for a post-service claim, received by the Plan or its authorized agent(s), to the Claim Administrator with instructions to provide a directive regarding such appealed claim.

When the Plan Administrator assigns the PACE the task of making a determination regarding second level internal appeals for post-service claims, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator only insofar as it relates to said second level internal appeal determinations for post-service claims. Assignment is achieved by and when the Plan Administrator advances a request for a second level appeal for a post-service claim, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding such appealed claim.

E. Fiduciary Liability The Plan Administrator is the named fiduciary under the Plan except as to the fiduciary duties extended to the Claim Administrator and the PACE.

The Claim Administrator's fiduciary duties extend only to those determinations actually made by the Claim Administrator, and with which the Plan Administrator complies. The Claim Administrator may perform other tasks on behalf of and in consultation with the Plan Administrator, but not as a fiduciary of the Plan. The Claim Administrator shall only be deemed to be a fiduciary when making determinations regarding Plan coverage and claims examined via initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims. The Claim Administrator shall not have fiduciary duties in all other matters, including, but not limited to, other appeals that are not first level internal appeal determinations for pre-service and post-service claims or second level internal appeal determinations for pre-service claims, and matters the Plan Administrator is prohibited from referring to the Claim Administrator in accordance with applicable law and/or pre-existing contract.

The Claim Administrator shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator delegates fiduciary authority to the Claim Administrator regarding initial claim determinations, first level internal appeal determinations for pre-service and post-service claims, and second level internal appeal determinations for pre-service claims, the Claim Administrator shall have discretion to interpret the terms of this Plan, and the Claim Administrator possesses all duties and rights otherwise ascribed to the Plan Administrator, for this

purpose, in this limited scope only. In such instances, the Claim Administrator's determinations will be binding (and final related to second level internal appeal determinations for pre-service claims) on all interested parties, and failure to comply with said determination by the Plan Administrator, shall absolve the Claim Administrator of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator complies. The PACE may perform other tasks on behalf of and in consultation with the Plan Administrator, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding Plan coverage and claims examined via second level post-service appeals. The PACE shall not have fiduciary duties in all other matters, including, but not limited to, other appeals that are not second level post-service appeals, and matters the Plan Administrator is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator delegates fiduciary authority to the PACE to make a determination regarding a second level post-service appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

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

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

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

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

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

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

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

Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, makes initial claim and initial appeal determinations based on the specific terms of the Plan. Except for those duties delegated by the Plan Administrator to the Claim Administrator regarding initial claim determinations, first level internal appeal determinations for Pre-Service Care and Post-Service Care Claims, and second level internal appeal determinations for Pre-Service Care Claims, and to the PACE regarding second level Post-Service Care Claims, all as further detailed in this Section, 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 Plan Summary).

(2) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Person within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

(3) If the claim is denied in whole or in part, and the Covered Person disputes the determination, he or she may contact the Claim Administrator, or for prescription drugs the Prescription Benefit Manager, to confirm that the claim was properly processed. The Covered Person may also immediately file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims*, below). In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may also request a simultaneous external review.

(4) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will review the first internal appeal and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below). In cases of Urgent Care Claim denials based on medical judgment for which an expedited external review has been requested, the Independent Review Organization (IRO) will issue a determination.

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal with the Claim Administrator, 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 either (1) the PACE, who holds the authority to make the final determination about benefits payable under the Plan pertaining to second level internal appeal determinations for Post-Service Care Claims, or (2) the Claim Administrator, who holds the authority to make the final determination pertaining to benefits payable under the Plan for second level internal appeal determinations for all other types of claims. 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, and the Covered Person disputes the determination, the Covered Person (or authorized representative) has the right to request an external review by an independent review organization (IRO) within the time periods specified in Chart B, below. The IRO will review the denial and issue a final decision within the period specified for the type of claim that is the subject of the review (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below). The Covered Person may also elect to take legal action as may be available under section 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 Plan Document.

A. Who May File a Claim

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

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

B. Types of Claims

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

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

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

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

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

C. When and How to File a Claim

A Covered Person must submit, or ensure that his or her provider submits, an initial claim for inpatient benefits 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* may be submitted verbally by calling the Claim Administrator at (844) 926-2262 or by any method available for Non-Urgent Care Claims and Post-Service Care Claims.

(2) *Non-Urgent Care Claims* and *Post-Service Claims* may be filed electronically or using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

- Electronically
- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 329-4812

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

D. Initial Claim Determination

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

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

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

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

E. How Claims are Paid

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

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a claimant may file an internal appeal of the adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. Before filing an appeal, a claimant may first want to contact the Claim Administrator for medical claims or the Prescription Benefit Manager for prescription drug claims at the phone number(s) as shown below in (3) *How and Where to Submit Appeals* to verify that the claim was correctly processed under the terms of the Plan, however, he or she is not required to do so (as shown below in (3) *How and Where to Submit Appeals*).

Initial internal appeals must be filed within 180 days of the initial claim denial; second internal appeals must be filed within 60 days of the initial appeal denial; requests for external review (available for rescissions and claim denials based on medical judgment) must be filed within 4 months of the second internal appeal denial. Any appeal or request for external review received after these deadlines will be denied, but note that external review of an Urgent Care Claim may be requested

simultaneously with an initial internal appeal. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

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

(1) *Urgent Care Claim appeals or requests for external review* may be submitted verbally or in writing by calling or faxing the Claim Administrator for medical claims or verbally by calling the Prescription Benefit Manager for prescription claims as shown below in (3) *How and Where to Submit Appeals.* Upon request, Urgent Care Claim appeals based on a medical judgment may be submitted for external review simultaneously with the initial appeal.

(2) *Non-Urgent Care Claim appeals or requests for external review,* and *Post-Service Care Claim appeals or requests for external review* must be in writing and must be submitted to the Claim Administrator for medical claims. Call the Prescription Benefit Manager for prescription appeals as shown below in (3) *How and Where to Submit Appeals*.

(3) How and Where to Submit Appeals

Urgent Care Claim appeals, Non-Urgent Care Claim appeals and Post-Service Care appeals or requests for external review may be submitted to the Claim Administrator or the Prescription Benefit Manager using one of the following methods:

<table>
<tr><th colspan="2">Medical Appeals</th></tr>
<tr><td>Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
(844) 926-2262

<u>Mailing Address</u>:
Health Plans, Inc.
P.O. Box 5199
Westborough, MA 01581</td><td>Method:

▪ U.S. Mail
▪ Hand delivery
▪ Facsimile (FAX):(508) 329-4812</td></tr>
<tr><th colspan="2">Prescription Inquiries/Prior Authorization/Appeals</th></tr>
<tr><td colspan="2">Covered Persons should contact the Prescription Benefit Manager directly at the telephone number listed on his/her ID card for directions on submitting appeals.</td></tr>
</table>

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

(1) The patient's name

(2) The patient's Plan identification number

(3) 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)

(4) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal or request for external review

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

- Review pertinent documents and submit issues and comments in writing.
- Request the billing and diagnosis codes related to the claim if the Covered Person believes a coding error may have caused the denial.

- Automatically receive any new or additional evidence or rationale considered, relied upon or generated by the Plan in connection with the claim as soon as possible so as to provide the Covered Person with reasonable time to respond before the final internal determination is issued.

- Designate an authorized representative to act on the Covered Person's behalf for the purposes of the appeal or request for external review.

- Submit written comments, documents, records, or any other matter relevant to his or her appeal or request for external review, even if the material was not submitted with the initial claim.

- Have reasonable access to, and copies of, all documents, records, and other information relevant to his or her appeal or request for external review, upon request and free of charge.

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

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

If the second appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon which the denial was based. In the event that a second appeal is denied, and the denial involved a rescission or was based in whole or in part on medical judgment, the claimant will have 4 months to request an external review. In filing a request for an external review, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial and second appeal. The Claim Administrator will conduct a preliminary review of the request to determine if the claim is eligible for external review and will provide timely notification to the claimant, in accordance with the requirements of federal law, as to whether the claim is eligible and whether any additional information is needed if the request is incomplete. If the claim is related to Pre-Service Care Claims and is eligible for external review, the Claim Administrator will assign the review to an IRO on a random basis, rotating assignments among IROs. If the claim is related to Post-Service Care Claims and is eligible for external review, the Claim Administrator will provide all applicable information to the PACE, whereupon, the PACE will assign the review to an IRO on a random basis, rotating assignments among IROs. In either case, the IRO will review the Plan's denial "de novo" and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. The IRO's determination will be binding on the Plan and the Covered Person, except to the extent that other remedies are available under state or federal law. If the IRO overturns the Plan's denial, the Plan will provide coverage or payment for the services regardless of whether the Plan intends to seek other remedies available under state or federal law.
For appeals of denials based on reasons other than rescissions or medical judgment, the second internal appeal is the final appeal available to the Covered Person and there is no further review available under the Plan. However, Covered Persons may have other remedies available under state or federal law, such as filing a lawsuit.

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

CHART B – Time Limits Regarding Initial and Internal Second Appeals and Request for External Review						
Type of Claim	**Maximum period for Claimant to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Claimant to file second internal appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**	**Maximum period for Claimant to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including Urgent Concurrent Care Claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	4 months	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CARE CLAIMS	180 days	15 days	60 days	15 days	4 months	45 days
POST-SERVICE CARE 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 Plan Summary. 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 Plan Summary 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 be able to request an external review or file suit in a state or federal court after exhausting the internal appeals 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 the Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

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

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.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #7 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JANUARY 1, 2021

This Plan is amended to include the following updates: add provision for certain specialty drugs accessed through Accredo Health Group, Inc. under the Prescription Drug Benefit and Injectables benefit; update limitations on Annual Aortic Aneurysm Screening; change the benefit limits on Chiropractic Care and Acupuncture; change the Emergency Room Co-payment; change telemedicine benefit and also extend telemedicine services to include coverage for e-Visits/virtual visits; add Health Coaching; 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. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

- **PRESCRIPTION DRUG BENEFIT**; The following provision is hereby **added** in its entirety:

  Your prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy effective January 1, 2021. At that time, you will no longer be covered for those specialty medications through your medical benefit. The list of medications subject to the program is available by calling the number on your prescription drug ID card.

- **PREVENTIVE CARE**; **Abdominal Aortic Aneurysm Screening** is hereby **deleted** and **replaced** in its entirety with the following:

PREVENTIVE CARE	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
The preventive care services marked below with ** are provided according to the terms prescribed by the regulations issued under the Patient Protection and Affordable Care Act of 2010, as may be amended from time to time. Please see the Medical Benefits section for additional details about the preventive coverage provided.		
****Abdominal Aortic Aneurysm Screening** (For Covered Persons age 65 and over) Up to one (1) per person, per lifetime	$20 Co-payment per visit, then 100%	Not Covered, except for services rendered by HPHC Providers covered at the In-Network level of benefits (subject to Allowed Amount)

***These maximums are combined In-Network and Out-of-Network maximums.**

- **PHYSICIAN SERVICES**; **Chiropractic Services** is hereby **deleted** and **replaced** in its entirety with the following:

PHYSICIAN SERVICES	**IN-NETWORK PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Chiropractic Services Up to 16* visits per person per Calendar Year	$20 Co-payment per visit, then 100%	Not Covered, except for services rendered by HPHC Providers covered at the In-Network level of benefits (subject to Allowed Amount)

***These maximums are combined In-Network and Out-of-Network maximums.**

- **HOSPITAL SERVICES-OUTPATIENT**; **Emergency Room Expenses** is hereby **deleted** and **replaced** in its entirety with the following:

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) (Co-payment is waived if admitted for observation or on an inpatient basis to a Hospital)	$150 Co-payment per visit, then 100%	$150 Co-payment per visit, then 100% Allowed Amount for Emergency Care as defined by the Plan

- **OTHER SERVICES & SUPPLIES; Acupuncture, Injectables** and **Telemedicine** are hereby **deleted** and **replaced** in their entirety with the following:

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture Up to 16* visits per person per Calendar Year	$20 Co-payment per visit, then 100%	Not Covered, except for services rendered by HPHC Providers covered at the In-Network level of benefits (subject to Allowed Amount)
Injectables *(Precertification required for treatments in excess of $2,000)* Note: Precertification does not apply to Chemotherapy support drugs; *See* Chemotherapy & Radiation Therapy benefit *for other limitations* Please contact Express Scripts for additional information regarding coverage and limitations under the Prescription Drug Program Your prescription drug program requires that certain specialty medications be accessed through Accredo Health Group, Inc., an Express Scripts specialty pharmacy effective January 1, 2021. At that time you will no longer be covered for those specialty medications through your medical benefit. The list of medications subject to the program is available by calling the number on your prescription drug ID card.	$5 Co-payment per visit, then 100%	Not Covered
Telemedicine (Applies to medical and behavioral health services; includes Doctor on Demand; *see* Medical Benefits *section for additional information*) All other virtual visits with a Provider with whom a Covered Person has established relationship, including, but not limited to Occupational Therapy, Physical Therapy and Speech Therapy	100% Paid based on services provided	100% Allowed Amount (Deductible waived) Paid based on services provided

***These maximums are combined In-Network and Out-of-Network maximums.**

- **WELLNESS BENEFITS; Health Coaching** is hereby **added** in its entirety as follows:

WELLNESS BENEFITS	ALL PROVIDERS
Health Coaching (Hypertension Care Rewards Program)	For Covered Persons age 18 and older who have been diagnosed with hypertension, the Plan will pay 100% up to a total reimbursement of $150 per person, per Calendar Year for participation in and completion of the Hypertension Care Rewards Program. A certificate issued from a TrestleTree Health Coach is required before reimbursement can be made. Contact AchieveHealth at 866-234-4635 for details.

SECTION V. MEDICAL BENEFITS, C. Covered Services;

- **(10) Other Covered Services and Supplies, 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

- **(11) Wellness Benefits; Health Coaching** is hereby **added** in its entirety with the following:

  Health Coaching (Hypertension Care Rewards Program)

SECTION VI. MEDICAL LIMITATIONS AND EXCLUSIONS is hereby amended by **adding** the following exclusion 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 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 Mandate 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 VII. 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.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #6 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JANUARY 1, 2021

This Plan is amended to change the claims submission requirement for Fitness Reimbursement. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS:

- **WELLNESS BENEFITS; Fitness Reimbursement Benefit** is hereby **deleted** and **replaced** in its entirety with the following:

WELLNESS BENEFITS	ALL PROVIDERS
Fitness Reimbursement Benefit	100% up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees. (Claims must be submitted by March 31st for reimbursement for the prior year. The paid date must be within your dates of enrollment in this Plan.)

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #5 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: MARCH 13, 2020

The purpose of this amendment is to revise the Plan Summary to update the Employer/Plan Sponsor address. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION II. GENERAL INFORMATION, Employer/Plan Sponsor is hereby **deleted** and **replaced** in its entirety with the following:

Employer/Plan Sponsor:	Boston Medical Center (the "Employer") 720 Harrison Avenue, 5th Floor Boston, MA 02118 (617) 638-8500

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #4 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JUNE 1, 2020

The purpose of this amendment is to revise the Plan Summary to add an Immigration Exam. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV. SCHEDULE OF MEDICAL BENEFITS; PHYSICIAN SERVICES, Immigration Exam is hereby **added** in its entirety in order to provide coverage at the levels shown below:

PHYSICIAN SERVICES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Immigration Exam (Includes related services)	$100 Co-payment per visit, then 100% (Note: Services must be rendered by a Boston Medical Center Civil Surgeon Provider only)	Not Covered

SECTION V. MEDICAL BENEFITS, C. Covered Services, (4) Physician Services, (d) Immigration Exam is hereby **added** in its entirety with the following, and all affected items are hereby re-ordered accordingly:

(4) Physician Services

(d) Immigration Exam

Immigration medical examination (or Civil Surgeon examination) will include a medical and immunization history, and blood/urine tests for syphilis, tuberculosis (with a follow up chest x-ray as needed), gonorrhea and a physical examination. The physical examination will include at a minimum: examination of the eyes, ears, nose and throat, extremities, heart, lungs, abdomen, lymph nodes, skin and external genitalia. Covered services include serologic tests or vaccinations as needed.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC Select)
AMENDMENT #3 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JUNE 1, 2019

This Plan is amended to add a precertification provision for spine surgery and spine pain management and a Diabetic Connect Program. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV, SCHEDULE OF MEDICAL BENEFITS; The following **Precertification for Other Specific Treatments** provision is hereby **added** in its entirety:

Precertification for Other Specific Treatments Required

Precertification for Medical Necessity is required for the following non-emergent spine surgeries:

- Lumbar microdiscectomy
- Lumbar decompression (laminotomy, laminectomy, facetectomy, foraminotomy)
- Lumbar spine fusion (arthrodesis)

In addition, precertification for Medical Necessity is required for treatment for Out-patient interventional spine pain management services not performed in the Emergency Room or while Inpatient, including:

- Spinal epidural injections
- Paravertebral facet joint injections/blocks
- Paravertebral facet joint denervation (radiofrequency neurolysis)

Failure to obtain the precertification in advance of these procedures or services will result in a reduction of benefits in the amount of $500 per admission for Inpatient surgery and $500 per procedure for outpatient services.

SECTION V, MEDICAL BENEFITS; The following paragraph **C. Diabetic Connect Program** is hereby **added** in its entirety, with all subsequent paragraphs re-lettered accordingly:

C. Diabetic Connect Program

For those Covered Persons who are diagnosed with diabetes, the Diabetic Connect Program is a diabetes monitoring, intervention, and personalized coaching program which offers Covered Persons access to mobile health solution that incorporates a cellular-enabled glucose meter along with patient tools, care team portals, and self-management support and coaching.

Covered Persons who choose to participate in this program may receive coverage for the following diabetes testing supplies:

- Cellular-enabled, wireless glucose meter
- Diabetes testing strips
- Control solution
- Lancets
- Lancing device(s)

The Diabetic Connect Program provides 100% reimbursement/payment for diabetes testing/supplies and services when obtained through the program through participating vendors, providers, pharmacies or suppliers. Covered Persons will not have any Co-payment, Coinsurance or Deductible through this program.

Participation in the Diabetic Connect Program is voluntary. For those Covered Persons who choose to participate in this program, coverage for diabetes treatment/services or supplies obtained from any other non-participating vendor, provider, pharmacy or supplier will not be covered under this program.

Please refer to the Schedule of Medical Benefits and Medical Benefits sections for Covered Services related to diabetes management when obtained directly through the Medical Plan.

SECTION VI, MEDICAL LIMITATIONS AND EXCLUSIONS; Item (37) Pain management programs/clinics is hereby **deleted** and **replaced** in its entirety with the following:

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

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC SELECT)
AMENDMENT #2 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JANUARY 1, 2019

This Plan is amended to increase Prescription Drug Benefit Co-payments under the Retail Card and Mail Order Pharmacy programs and add coverage for specialty drugs; remove the reduction in payment for a private room when the Hospital only has private rooms; increase the Emergency Room Co-payment; add coverage for Acupuncture; clarify that cancer support medications are not subject to precertification for Injectables; update the list of exclusions related to Gender Dysphoria Treatment and outline that retrieval, cryopreservation, and storage of sperm or eggs are covered when gender reassignment treatment is likely to result in infertility; and prohibit the assignment of a member's interests under the Plan. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV, SCHEDULE OF MEDICAL BENEFITS

- **Prescription Drug Benefit** is hereby **deleted** and **replaced** in its entirety in order to provide coverage at the levels shown:

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS	
Prescription Drug Expense & Mail Order Option Generic U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100%. Preferred brand name and non-preferred brand name contraceptive medications are subject to shown above, unless the generic form is not available. In that case, the available preferred brand name drug (or non-preferred brand name if preferred brand name is not available) will be covered at 100% Tobacco cessation products are covered at 100% Note: Prescription drug Co-payment and Coinsurance amounts accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximum has been met, prescription drugs will be covered at 100% for the balance of the Calendar Year.	**BMC Employee Pharmacy Retail Card Program – You Pay:** (Up to a 30 day supply) $5 Co-payment per generic drug; $10 Co-payment per preferred brand name drug; $20 Co-payment per non-preferred brand name drug; $20 Co-payment per specialty drug **BMC Employee Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $60 Co-payment per non-preferred brand name drug; $60 Co-payment per specialty drug. **Retail Card Program – You Pay:** (Up to a 30 day supply) $20 Co-payment per generic drug; $40 Co-payment per preferred brand name drug; $80 Co-payment per non-preferred brand name drug. 20% Coinsurance per specialty drug, up to $250 maximum **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $40 Co-payment per generic drug; $80 Co-payment per preferred brand name drug; $240 Co-payment per non-preferred brand name drug 20% Coinsurance per specialty drug, up to $750 maximum
Out-Of-Network Pharmacy Coverage	NOT COVERED

- **HOSPITAL SERVICES—IN PATIENT** and **MENTAL HEALTH/SUBSTANCE ABUSE** are hereby **deleted** and **replaced** in their entirety with the following:

HOSPITAL SERVICES – INPATIENT	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan. **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%	Not Covered
Maternity Services *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	100%	Not Covered
Birthing Center	100%	Not Covered
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	100%	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	100%	Not Covered
Surgical Facility & Supplies	100%	Not Covered
Miscellaneous Hospital Charges	100%	Not Covered

MENTAL HEALTH/ SUBSTANCE ABUSE	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan. **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%	Not Covered
Partial Hospitalization/Intensive Outpatient Treatment *(Precertification required)*	100%	Not Covered
Inpatient Physician Visit	100%	Not Covered
Hospital Clinic Visit	$5 Co-payment per visit, then 100%	Not Covered
Office Visit	$5 Co-payment per visit, then 100%	Not Covered
Methadone Maintenance/ Treatment	$5 Co-payment per visit, then 100%	Not Covered

- **HOSPITAL SERVICES—OUTPATIENT, Emergency Room Expenses** is hereby **deleted** and **replaced** in its entirety with the following:

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) (Co-payment is waived if admitted for observation or on an inpatient basis to a Hospital)	$125 Co-payment per visit, then 100%	$125 Co-payment per visit, then 100% Allowed Amount for Emergency Care as defined by the Plan

- **OTHER SERVICES & SUPPLIES, Acupuncture tables** is hereby **added** in its entirety in order to provide coverage at the levels shown:

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Acupuncture Up to $500 per person, per Calendar Year	$20 Co-payment per visit, then 100%	$20 Co-payment per visit, then 100% Allowed Amount

***These maximums are combined In-Network and Out-of-Network maximums.**

- **OTHER SERVICES & SUPPLIES, Chemotherapy & Radiation Therapy** and **Injectables** are hereby **deleted** and **replaced** in their entirety with the following:

OTHER SERVICES & SUPPLIES	IN-NETWORK PROVIDERS	OUT-OF-NETWORK PROVIDERS
Chemotherapy & Radiation Therapy Note: Precertification recommended for off-label usage or when chemotherapy is administered as part of an Approved Clinical Trial	100%	Not Covered
Injectables *(Precertification required for treatments in excess of $2,000)* Note: Precertification does not apply to Chemotherapy support drugs; *See* Chemotherapy & Radiation Therapy benefit *for other limitations* Note: Please contact Express Scripts for additional information regarding coverage and limitations under the Prescription Drug Program	$5 Co-payment per visit, then 100%	Not Covered

SECTION V, MEDICAL BENEFITS, C. Covered Services, (5) Hospital Services—Inpatient, (a) Hospital room & board is hereby **deleted** and **replaced** in its entirety with the following:

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital room and board for a semi-private 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 semi-private 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%

SECTION V, MEDICAL BENEFITS, C. Covered Services, (10) Other Covered Services and Supplies, (w) Infertility treatment is hereby **deleted** and **replaced** in its entirety with the following:

(10) Other Covered Services and Supplies

(w) Infertility treatment

Treatment of infertility including medicines, and surgical procedures

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.

SECTION VI, MEDICAL LIMITATIONS AND EXCLUSIONS, The exclusion for **Gender Dysphoria Treatment** is hereby **deleted** and **replaced** in its entirety with the following:

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.

SECTION XIV, GENERAL PROVISIONS, F. Interests not Transferable is hereby **deleted** and **replaced** in its entirety with the following:

F. Interests not Transferable

The interests of the Employee and their Eligible Dependents 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.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN (BMC Select)
AMENDMENT #1 TO THE
JANUARY 1, 2018 PLAN SUMMARY
EFFECTIVE: JANUARY 1, 2018

The purpose of this amendment is to revise the Plan Summary to add a provision for Ancillary Services under Important Notes; add coverage for Orthoptics/Vision Therapy; and cover Diagnostic X-ray and Laboratory (Outpatient) at the Out-of-Network level. All references to the provisions below that appear in any part of the Plan Document or in any prior amendments are also hereby amended to be consistent with the changes described below.

The Plan Summary is hereby amended as follows:

SECTION IV, SCHEDULE OF MEDICAL BENEFITS:

- **IMPORTANT NOTES** is hereby **deleted** and **replaced** in its entirety with the following:

IMPORTANT NOTES:

Emergency Care, urgent care, student health center 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, as well as routine vision exams, are covered under this Plan subject to the Allowed Amount. When these services are rendered by a network physician outside of the Covered Person's primary network area, they are covered at the In-Network level of benefits under this Plan. All other services rendered by an Out-of-Network or rendered by a Provider/facility outside of the Covered Person's primary network are not covered under this Plan, unless stated otherwise.

Out-of-Area Dependent Coverage (for Covered Dependents ages 19-25):
If there is no In-Network Provider, or no In-Network Provider is able to provide the necessary service(s) to the Covered Dependent within a 100-mile radius of the Covered Dependent's residence, then Out-of-Network charges will be covered as In-Network charges (subject to Allowed Amount when the Covered Dependent provides appropriate documentation.

Ancillary Services:
When a Covered Person receives services from an In-Network Provider or at an In-Network Facility in New England and ancillary services associated with this care are rendered by an Out of Network Provider, charges for these ancillary services are not subject to the Allowed Amount. Ancillary services include lab, x-ray, radiology, pathology and anesthesia. Covered Persons who are billed for these ancillary services in excess of the Allowed Amount by an Out-of-Network Provider/facility can submit the bill to the Claims Administrator for payment by the Plan.

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 Covered Person is also responsible to pay any amount above the Allowed Amount, as applicable, when services are rendered by an Out-of-Network Provider.

The following expenses are excluded from the Out-of-Pocket Maximum(s): Precertification penalties

- **VISION CARE, Orthoptics/Vision Therapy** is hereby **added** in its entirety in order to provide coverage at the levels shown below:

VISION CARE	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Orthoptics/Vision Therapy	$5 Co-payment per visit, then 100%	Not Covered

SECTION V, MEDICAL BENEFITS, C. Covered Services, (3) Vision Care; Subparagraph (c) is hereby **added** in its entirety:

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

SECTION VI, MEDICAL LIMITATIONS AND EXCLUSIONS, Item 35. Orthoptics and vision therapy for the correction of vision is hereby **deleted** in its entirety, with all subsequent items renumbered accordingly.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL BENEFIT PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS

The Medical Benefit Plan(s) offered by Boston Medical Center 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 Families First Coronavirus Response Act and 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.**

In the event of an employer-initiated leave resulting directly or indirectly from the coronavirus pandemic, coverage under the Plan will continue, provided the employee continues to make any required contribution:

Until the earliest of:

- Termination of employment for any reason
- The date the employee is recalled to work by the employer t to resume business operations interrupted during the coronavirus pandemic

Effective April 1, 2020

BOSTON MEDICAL CENTER.
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.

BOSTON MEDICAL CENTER
EMPLOYEE GROUP MEDICAL PLAN(S)
SUMMARY OF MATERIAL MODIFICATIONS

The Medical Benefit Plan(s) offered by Boston Medical Center and administered by Health Plans, Inc. are amended to include: a revised definition of Allowed Amount to clarify how payment for Out-of-Network Emergency Care services is made under the Plans; clarification that the Plan excludes claims related to state-mandated auto insurance for which the policy provides optional coverage to the extent the Covered Person elects such optional coverage; and to reflect revised administrative practices related to precertification requirements for chemotherapy and radiation therapy services. 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 update the provisions below, effective as of the date specified for each provision:

The current definition of Allowed Amount is replaced with the following:

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. Covered Persons may be responsible for paying the balance of these claims after the Plan pays its portion, if any. The Allowed Amount for services received from an Out-of-Network Provider depends upon where the services are provided.

Out-of-Network non-Emergency Care Received In New England

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

An amount that is consistent with historically accepted reimbursements, commercial pricing benchmarks, accepted Medicare rates, preferred provider contractual reimbursements and geographic adjustments

Out-of-Network non-Emergency Care Received Outside New England

If non-Emergency Care is received from an Out-of-Network Provider located outside of New England, payment of 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.

Out-of-Network Emergency Care

If Emergency Care is received in the emergency department of an Out-of-Network Hospital, the Plan will cover the services at the In-Network Deductible, Co-payment and Coinsurance levels, as applicable, and the Out-of-Network Provider will be paid an Allowed Amount defined as an amount based on either: i) a discount agreement; ii) a provider network rate; or iii) a negotiated amount. If the claim cannot be priced at one of the foregoing amounts, the Allowed Amount will be paid at billed charges.

Effective January 1, 2018

The following provisions related to mandatory no-fault automobile insurance are replaced with the following:

MEDICAL LIMITATIONS AND EXCLUSIONS

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 to the extent the Covered Person elects such optional medical coverage. This exclusion does not apply if the injured Covered Person is a passenger in a non-family owned vehicle or a pedestrian.

COORDINATION OF BENEFITS

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 Medical Limitations and Exclusions provisions set forth in this Plan. This applies to all forms of medical payments under vehicle plans and/or policies regardless of their names, titles or classifications.
Effective January 1, 2021

Precertification requirements for chemotherapy and radiation therapy services are revised as follows:

- Precertification is not required for chemotherapy support drugs; precertification is required for all other chemotherapy services, including services administered in a physician's office

- Precertification is required for Intensity-Modulated Radiation Therapy (IMRT)
  Effective November 1, 2021

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 PLAN SUMMARY

I, the undersigned, acknowledge receipt of the Plan Summary 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 Plan Summary.

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 Plan Summary. By my following signature, I acknowledge receipt of the Plan Summary and that I am aware of my rights under COBRA and the Special Enrollment Periods and Elections.

Boston Medical Center

_____

Employee Name (Please Print)

_____

Employee Signature

_____

Date

INDEX

I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by Boston Medical Center (hereinafter the "Employer") on this 1st day of January, 2018 sets forth the Boston Medical Center Employee Group Medical Plan (BMC Select) effective as of January 1, 2018.

A. Establishment of Plan

The Employer hereby sets forth its group health plan known as the Boston Medical Center Employee Group Medical Plan – BMC Select (the "Plan"). The Plan is written for the sole and exclusive purpose of providing to the Employees and their Eligible Dependents employee medical and prescription drug benefits as described herein. These benefits have been established by the Employer and are provided on a self-funded basis. As such, the benefits are directly funded through and provided by the Employer, and the 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 these benefits.

B. Effective Date

The Plan as described herein is effective as of January 1, 2018.

C. Applicable Law

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

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

The Plan Summary is based on a number of legal documents that may include policies, contracts, collective bargaining agreements, plan documents and trust agreements. Although the Plan Summary 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.healthplansinc.com/bmc to search the online provider directory or call the Health Plans, Inc. Customer Service Department at (844) 926-2262 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:	Boston Medical Center Employee Group Medical Plan – BMC Select
Type of Plan:	Welfare plan providing medical and prescription drug benefits on a self-funded basis
Effective Date:	January 1, 2018
Employer/Plan Sponsor:	Boston Medical Center (the "Employer") 85 East Concord Street, 2nd Floor Boston, MA 02118-2393 (617) 638-8500
ERISA Plan Number:	504
Employer Identification Number:	04-3314093
Group Number:	006B87
Plan Administrator:	Employer (see above)
Claim Administrator:	Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 https://www.healthplansinc.com (844) 926-2262
Plan Appointed Claim Evaluator ("PACE"):	The Phia Group, LLC 163 Bay State Drive Braintree, MA 02184
Prescription Benefit Manager:	Express Scripts, Inc. 1400 Riverport Drive Maryland Heights, MO 63043 (800) 524-4491
Case Management Services:	Care Management Services Department (Care Management Services) Health Plans, Inc. P.O. Box 663 Westborough, MA 01581 (844) 926-2262
COBRA Administrator:	Please refer to your Human Resources Department for additional information

Agent for Service of Legal Process:	Employer (see above)
Plan Cost:	Contributory
Plan Year Ends:	December 31st
Fiscal Year Ends:	September 30th
Loss of Benefits:	The Employer may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by a duly authorized officer of the Employer. An Employee's consent is not required to terminate or change the Plan. Participation in and coverage under this Plan for any Employee and his or her Eligible Dependents terminates in accordance with the provisions established by the Plan Sponsor. Employees should contact the Plan Sponsor for termination provisions that apply to them and their Eligible Dependents. 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' coverage under the Plan, or 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 rescissions (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 day off 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

Break-in-Service – following an Employee's termination of employment: a period of 13 or more consecutive weeks during which an Employee has not had an hour of service

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 80%, the Plan pays 80% and the Covered Person pays 20%, 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 or dependent 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 Dependent –

(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, 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 subsections (2) and (3) above, "Employee's child" means:

(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 (as detailed below);

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 after the last day of the month 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 detailed 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.

Emergency Care – care administered in a Hospital, clinic, or Physician'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

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

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 requires review and approval by the treating facility's institutional review board or other body serving a similar function, or 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

Health Insurance Marketplace or Exchange – a resource available in each state that helps individuals learn about health coverage, and about paying for health coverage and available subsidies, and offers individuals and families the opportunity to enroll in Qualified Health Plans.

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; and

(4) It has an administrator

Hospice Plan of Care – a prearranged, written outline of care for the palliation and management of a Covered 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 facilities 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; or a residential treatment facility specializing in the care and treatment of mental illness, 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 – an 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 includes hospice facilities 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(s) as a Registered Nurse (R.N.), a Licensed Practical Nurse (L.P.N.) or 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 Appointed Claim Evaluator or "PACE" – an entity appointed by the Plan Administrator to make final, binding decisions regarding the payment of benefits under the Plan pertaining to second level appeal determinations for post-service claims

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

Qualified Health Plan – a health plan offered through and certified by a Health Insurance Marketplace

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 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 lawfully married to a person. Individuals who have entered into a registered domestic partnership, civil union, or other similar relationship that is not a lawful marriage under state (or foreign) law are not considered Spouses for federal tax purposes. For more details, see IRS Publication 501.

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 provided in accordance with the standards and frequencies recommended by the United States Preventive Services 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. Precertification is not a guarantee of payment. Services which require precertification, regardless of whether the service is rendered inpatient, outpatient, or in an office setting, are identified on the following Schedule of Medical Benefits chart. Precertification is provided by an affiliate or a designee of Health Plans, Inc.

Call the Care Management Services Department at (844) 926-2262 prior to receiving services shown as requiring precertification to confirm the Medical Necessity of the proposed services.

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 always required.

If a Covered Person is scheduled to be admitted to a Hospital, he or she must have the hospitalization precertified under the Plan prior to the date of admission or within two business days of admission in the case of emergency admissions.

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.

Failure to obtain precertification for inpatient services may result in a reduction in benefits. Any reduction in benefits for inpatient services cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximums under this Plan.

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

Other Questions Regarding Eligibility and Benefits

Please contact the Claim Administrator at (844) 926-2262 for 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.

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS	
Prescription Drug Expense & Mail Order Option Generic U.S. Food and Drug Administration (FDA) approved contraceptive medications and devices are covered at 100%. Preferred brand name and non-preferred brand name contraceptive medications are subject to Co-payments shown above, unless the generic form is not available. In that case, the available preferred brand name drug (or non-preferred brand name if preferred brand name is not available) will be covered at 100% Tobacco cessation products are covered at 100%	**BMC Employee Pharmacy Retail Card Program – You Pay:** (Up to a 30 day supply) $5 Co-payment per generic drug; $10 Co-payment per preferred brand name drug; $20 Co-payment per non-preferred brand name drug. **BMC Employee Pharmacy – You Pay:** (Up to a 90 day supply) $10 Co-payment per generic drug; $20 Co-payment per preferred brand name drug; $60 Co-payment per non-preferred brand name drug. **Retail Card Program – You Pay:** (Up to a 30 day supply) $20 Co-payment per generic drug; $35 Co-payment per preferred brand name drug; $50 Co-payment per non-preferred brand name drug. (Specialty drugs are subject to the co-payments shown above) **Mail Order Pharmacy – You Pay:** (Up to a 90 day supply) $40 Co-payment per generic drug; $70 Co-payment per preferred brand name drug; $150 Co-payment per non-preferred brand name drug Note: Prescription drug Co-payment amounts accumulate toward the Out-of-Pocket Maximum (shown below). Once the Out-of-Pocket Maximum has been met, prescription drugs will be covered at 100% for the balance of the Calendar Year.
Out-Of-Network Pharmacy Coverage:	NOT COVERED

MEDICAL BENEFITS		
BENEFIT LEVELS:	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Medical Calendar Year Deductible*	NONE per person NONE per family	Not Covered
Reimbursement Percentage ("Coinsurance")	100% of the Contracted Rate (unless otherwise stated) until the Out-of-Pocket Maximum has been reached	Not Covered
Calendar Year Out-of-Pocket Maximums* (Including all applicable Co-payments, Coinsurance and the Calendar Year Deductible, including those for prescription drugs)	Single (Employee only): $2,500 per person Family (Employee & family): $2,500 per person; up to $5,000 per family	Not Covered
Note: 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.		
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, as well as routine vision exams, are covered under this Plan, subject to the Allowed Amount. When these services are rendered by a network physician outside of the Covered Person's primary network area, they are covered at the In-Network level of benefits under this Plan. All other services rendered by an Out-of-Network or rendered by a Provider/facility outside of the Covered Person's primary network are not covered under this Plan, unless stated otherwise. **Out-of-Area Dependent Coverage (for Covered Dependents ages 19-25):** If there is no In-Network Provider, or no In-Network Provider is able to provide the necessary service(s) to the Covered Dependent within a 100-mile radius of the Covered Dependent's residence, then Out-of-Network charges will be covered as In-Network charges (subject to Allowed Amount) when the Covered Dependent provides appropriate documentation. **The following expenses are excluded from the Out-of-Pocket Maximum(s):** • Precertification penalties ***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	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
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 and travel immunizations, and flu shots)	100%	Not Covered
****Routine Well Child Care** (Including screenings, routine and travel immunizations, and flu shots)	100%	Not Covered
****Fluoride Varnish** (For Covered Persons up to age 6) Up to four (4) varnish treatments per person, per Calendar Year	100%	Not Covered
****Breastfeeding Support, Supplies and Counseling** (During pregnancy and/or in the postpartum period and rental or purchase of breastfeeding equipment) Breast Pump Limits: • 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%	Not Covered
**** Contraceptive Services and Supplies for Women** (FDA approved only; includes education and counseling)	100%	Not Covered
****Routine Gynecological/ Obstetrical Care** (Including preconception and prenatal services)	100%	Not Covered
****Routine Pap Smears**	100%	Not Covered
**** Breast Cancer Screening including Routine Mammograms and BRCA Testing**	100%	Not Covered
****Routine Immunizations** (If not billed with an office visit; includes flu shots and travel immunizations)	100%	Not Covered

PREVENTIVE CARE	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
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 Lab, X-rays, and Clinical Tests** (Including those related to maternity care)	100%	Not Covered
****Routine Colorectal Cancer Screening, including sigmoidoscopies and colonoscopies** (Age 50 and older)	100%	Not Covered
****Lung Cancer Screening, including Low-Dose Computed Tomography (LDCT)** (Age 55 and older) Up to one (1) per person, per Calendar Year	100%	Not Covered
****Nutritional Counseling**	100%	Not Covered
****Smoking Cessation Counseling and Intervention** (Including smoking cessation clinics and programs)	100%	Not Covered
Routine Hearing Exams	$5 Co-payment per visit, then 100%	Not Covered
Routine Prostate Exams and Prostate-Specific Antigen (PSA) Screenings	100%	Not Covered
****Abdominal Aortic Aneurysm Screening** (For men age 65 and over) Up to one (1) per person, per lifetime	100%	Not Covered
****Bone Density Screening**	100%	Not Covered

PREVENTIVE CARE	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
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 13) Limited to the following services: • Complete initial oral exam by child's dentist • Up to two (2) periodic oral exams per person, per Calendar Year • Up to two (2) cleanings per person, per Calendar Year • Up to two (2) fluoride treatments per person, per Calendar Year • Up to two (2) sets of bitewing x-rays per person, per Calendar Year	$5 Co-payment per visit, then 100%	Not Covered

VISION CARE	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Routine Vision Exam (Includes contact lens fitting) Up to one (1) exam per person, per Calendar Year	$5 Co-payment per visit, then 100%	$5 Co-payment per visit, then 100% Allowed Amount
Eyewear for Special Conditions (Includes lenses necessary to treat certain medical conditions; *see* Medical Benefits *section for other limitations*)	100%	Not Covered

PHYSICIAN SERVICES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Allergy Testing	$5 Co-payment per visit, then 100%	Not Covered
Allergy Treatment	$5 Co-payment per visit, then 100%	Not Covered
Anesthesia (Inpatient/Outpatient)	100%	100% Allowed Amount
Chiropractic Services (Coverage for x-rays does not track to the dollar limit) Up to $500 per person, per Calendar Year	$20 Co-payment per visit, then 100%	Not Covered
Maternity (Includes Physician delivery charges, prenatal and postpartum care) Covered Persons are eligible to participate in the Healthy Pregnancy Program, a voluntary free program that provides support and resources for healthy moms and babies. For additional program information, call 888-975-8185, press 2 or email HealthyPregnancy@healthplansinc.com	100%	Not Covered
Physician Hospital Visits	100%	Not Covered
Physician Office Visits – Primary Care (Includes all related charges billed at time of visit)	$5 Co-payment per visit, then 100%	Not Covered
Physician Office Visits - Specialist (Includes all related charges billed at time of visit)	$5 Co-payment per visit, then 100%	Not Covered
Second Surgical Opinion	$5 Co-payment per visit, then 100%	Not Covered
Surgery (Inpatient)	100%	Not Covered
Surgery (Outpatient)	100%	Not Covered
Surgery (Physician's office)	$5 Co-payment per visit, then 100%	Not Covered

HOSPITAL SERVICES – INPATIENT	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**		
Hospital Room & Board *(Precertification required)* Semi-private room or special care unit	100%	Not Covered
Maternity Services *(Precertification required for stays in excess of 48 hours[vaginal]; 96 hours [cesarean])* Semi-private room or special care unit	100%	Not Covered
Birthing Center	100%	Not Covered
Newborn Care (Includes Physician visits & circumcision) Semi-private room or special care unit	100%	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	100%	Not Covered
Surgical Facility & Supplies	100%	Not Covered
Miscellaneous Hospital Charges	100%	Not Covered

HOSPITAL SERVICES – OUTPATIENT	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Clinic Services (At a Hospital)	$5 Co-payment per visit, then 100%	Not Covered
Emergency Room Expenses (Includes Facility, Lab, X-ray & Physician services) (Co-payment is waived if admitted for observation or on an inpatient basis to a Hospital)	$75 Co-payment per visit, then 100%	$75 Co-payment per visit, then 100% Allowed Amount
Outpatient Department	100%	Not Covered
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	100%	Not Covered
Preadmission Testing	100%	Not Covered
Student Health Centers	$5 Co-payment per visit, then 100%	$5 Co-payment per visit, then 100% Allowed Amount
Urgent Care Facility/Walk-In Clinic	$5 Co-payment per visit, then 100%	$5 Co-payment per visit, then 100% Allowed Amount
MENTAL HEALTH/ SUBSTANCE ABUSE	**IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS**	**OUT-OF-NETWORK PROVIDERS**
Precertification is always required for inpatient hospitalization. **Failure to obtain precertification may result in a reduction in benefits.** The reduction in benefits cannot be used to satisfy any applicable Co-payments, Deductibles or Out-of-Pocket Maximum under this Plan. **Any penalty incurred due to failure to obtain notification or prior authorization for services is the responsibility of the Covered Person.**		
Inpatient Hospitalization *(Precertification required)*	100%	Not Covered
Partial Hospitalization/Intensive Outpatient Treatment *(Precertification required)*	100%	Not Covered
Inpatient Physician Visit	100%	Not Covered
Hospital Clinic Visit	$5 Co-payment per visit, then 100%	Not Covered
Office Visit	$5 Co-payment per visit, then 100%	Not Covered
Methadone Maintenance/ Treatment	$5 Co-payment per visit, then 100%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Ambulance Services (*See* Medical Benefits *section for limitations*)	100%	100% Allowed Amount
Autism Spectrum Disorders Treatment (Includes Applied Behavior Analysis (ABA); benefit limits do not apply to occupational, physical, and speech therapies; *precertification for Medical Necessity is required* for ABA – *see* Medical Benefits *section for other limitations*) Note: Screenings are covered under Preventive Care	ABA: $5 Co-payment per visit, then 100% All other benefits are based on services provided	Not Covered
Bariatric Surgery (When related to treatment of Morbid Obesity; *precertification required*; *see* Medical Benefits *section for other limitations)*	100%	Not Covered
Cardiac Rehabilitation (Phase 1 and 2 only; *see* Medical Benefits *section for other limitations*)	$5 Co-payment per visit, then 100%	Not Covered
Chemotherapy & Radiation Therapy Note: Precertification recommended for off-label usage or when chemotherapy is administered as part of an Approved Clinical Trial	100%	Not Covered
Clinical Trials – Routine Services during Approved Clinical Trials (Limited to Routine Covered Services under the Plan, including Hospital visits, laboratory, and imaging services)	Benefits are based on services provided	Not Covered
Cochlear Implants *(Precertification required)*	100%	Not Covered
Dental/Oral Services (Includes excision of impacted wisdom teeth; *see* Medical Benefits *section for other limitations*)	Office visit: $5 Co-payment per visit, then 100% All other: 100%	Not Covered
Diabetes Self-Management Training and Education	100%	Not Covered
Diagnostic Imaging (MRI, CT Scan, PET Scan)	100%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Diagnostic X-ray and Laboratory (Outpatient)	100%	Not Covered
Dialysis/Hemodialysis *(Precertification required for initial treatment; see* Medical Benefits *section for other limitations)* Installation of home equipment is covered up to $300 per person, per lifetime:	$5 Co-payment per visit, then 100% 100%	Not Covered
Durable Medical Equipment *(Precertification required for equipment rental in excess of three (3) months, TENS units, and equipment in excess of $1,000; see* Medical Benefits *section for other limitations)*	80% Oxygen and respiratory equipment and blood glucose monitors, infusion devices and insulin pumps (including supplies) covered 100%	Not Covered
Early Intervention Services (*See* Medical Benefits *section for other limitations*) (Up to age 3) Up to $5,200 per person, per Calendar Year and $15,600 per person, per lifetime	100%	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% 100%	 Not Covered Not Covered
Gender Dysphoria Treatment and Related Services (Includes coverage for 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	Not Covered
Genetic Counseling, Testing and Related Services *(Precertification required for genetic testing)* (Note: Coverage is provided for BRCA Testing – See Breast Cancer Screening in Preventive Care Services; Precertification is not required)	100%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Hearing Aids Up to $1,000 per person, per hearing aid every 36 months, for each hearing impaired ear	100%	Not Covered
Home Health Care *(Precertification required; see* Medical Benefits *section for other limitations)*	100%	Not Covered
Hospice Care (Inpatient/Outpatient) *(Precertification required; see* Medical Benefits *section for other limitations)*	100%	Not Covered
Infertility Treatment *(Precertification required; see Medical Benefits section for other limitations)* Assisted reproductive technologies include, but are not limited to: • In vitro fertilization (IVF-ET) • Gamete intrafallopian transfer (GIFT) • Zygote intrafallopian transfer (ZIFT)	$5 Co-payment per office visit, then 100% 100%	Not Covered
Injectables *(Precertification required for treatments in excess of $2,000)* (Note: Please contact Express Scripts for additional information regarding coverage and limitations under the Prescription Drug Program)	$5 Co-payment per visit, then 100%	Not Covered
Marital Counseling	$5 Co-payment per visit, then 100%	Not Covered
Medical and Enteral Formula (Including metabolic formula; *precertification required; see* Medical Benefits *section for other limitations)*	100%	Not Covered
Modified Low Protein Food Products (S*ee* Medical Benefits *section for limitations*) Up to $5,00 per person, per Calendar Year	100%	Not Covered
Neuromuscular Stimulator Equipment including TENS *(Precertification required as noted under the Durable Medical Equipment benefit)*	80%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Occupational Therapy (For treatment due to Illness, Injury, or developmental delay; *see* Medical Benefits *section for other limitations)* Up to 60 visits per person, per Calendar Year combined with Physical Therapy; limits do not apply to Covered Dependents under the age of three (3) if Medically Necessary	$5 Co-payment per visit, then 100%	Not Covered
Orthotics (Excludes foot orthotics except to treat diabetic conditions; s*ee* Medical Benefits *section for other limitations*)	80%	Not Covered
Physical Therapy (For treatment due to Illness, Injury, or developmental delay; *see* Medical Benefits *section for other limitations)* Up to 60 visits per person, per Calendar Year combined with Occupational Therapy; limits do not apply to Covered Dependents under the age of three (3) if Medically Necessary	$5 Co-payment per visit, then 100%	Not Covered
Podiatry Care *(See* Medical Benefits *section for limitations*)	$5 Co-payment per visit, then 100%	Not Covered
Prosthetics *(Precertification required as noted under the Durable Medical Equipment benefit; see* Medical Benefits *section for limitations*)	80%	Not Covered
Rehabilitation Hospital *(Precertification required*; s*ee* Medical Benefits *section for other limitations*) Up to 60 days per person, per Calendar Year	100%	Not Covered
Respiratory Therapy	$5 Co-payment per visit, then 100%	Not Covered
Skilled Nursing Facility/Extended Care Facility *(Precertification required; see* Medical Benefits *section for other limitations*) Up to 100 days per person, per Calendar Year	100%	Not Covered

OTHER SERVICES & SUPPLIES	IN-NETWORK BMC, HEALTHNET, COMMUNITY HEALTH CENTER AND BMC AFFILIATED PROVIDERS	OUT-OF-NETWORK PROVIDERS
Speech Therapy (For treatment due to Illness, Injury, or developmental delay; *precertification required*; s*ee* Medical Benefits *section for other limitations)*	$5 Co-payment per visit, then 100%	Not Covered
Telemedicine	$5 Co-payment per visit, then 100%	Not Covered
Temporomandibular Joint Disorders (TMJ) Treatment *(*For medical treatment only; dental care excluded; *precertification required)*	Benefits are based on services provided	Not Covered
Voluntary Sterilization	100%	Not Covered
Voluntary Termination of Pregnancy	100%	Not Covered
Wigs (When hair loss is due to cancer, leukemia, alopecia or permanent hair loss due to Injury; s*ee* Medical Benefits *section for other limitations*) Up to $350 per person, per Calendar Year	80%	Not Covered

WELLNESS BENEFITS	ALL PROVIDERS
Fitness Reimbursement Benefit	100% up to a total reimbursement of $150 per family, per Calendar Year for health club membership fees. (Must be paid in the current Calendar Year for membership in that year, and the paid date must be within your dates of enrollment in this Plan)

V. MEDICAL BENEFITS

A. Benefit Levels

In-Network BMC, HealthNet, Community Health Center and BMC Affiliated 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. **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.**

Out-of-Network Providers – Out-of-Network Providers will be paid at In-Network Provider Co-payment and Coinsurance levels subject to the Allowed Amount when covered ancillary medical services are rendered to a Covered Person on an inpatient or outpatient basis in an In-Network Hospital or facility and 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. **All other services rendered by an Out-of-Network Provider are not covered under this Plan.**

Out-of-Area Dependent Coverage (for Covered Dependents ages 19 through 25): If there is no In-Network Provider, or no In-Network Provider is able to provide the necessary service(s) to the Covered Dependent within a 100-mile radius of the Covered Dependent's residence, then Out-of-Network charges will be covered as In-Network charges (subject to Allowed Amount) when the Covered Dependent provides appropriate documentation.

All the rules and limits for coverage listed in this document and in the Schedule of Medical Benefits apply to Covered Services for Eligible Dependents when receiving medical services from a network provider outside of the 100-mile radius. **If an Eligible Dependent chooses 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.**

Important Notice: An Eligible Dependent residing outside of the 100-mile radius must be registered with Health Plans, Inc. to make use of this benefit. Eligible Dependents must complete an *Out-of-Area Dependent Coverage* form and submit to Health Plans, Inc. during the annual Open Enrollment period or within 30 days of moving outside of the 100-mile radius. ***Each Eligible Dependent must re-verify their out-of-area dependent status annually thereafter.*** To obtain a copy of this form, please refer to Health Plans, Inc.'s internet site at https://www.healthplansinc.com/bmc or call the Health Plans, Inc. Customer Service Department at **(844) 926-2262**.

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 In-Network Provider levels subject to the Allowed Amount.

Deductible – There is no Deductible that applies to Covered Services provided by In-Network Providers.

Out-of-Pocket Maximum – The Out-of-Pocket Maximums are shown in the Schedule of Medical Benefits. 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 Out-of-Pocket Maximum excludes charges in excess of the Allowed Amount and any penalties for failure to follow Preadmission/Precertification Requirements.

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 a 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 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 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; and

(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.

(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 and tests billed at the time of visit, including, but not limited to x-rays, laboratory and clinical tests and routine immunizations. Covered Services include, but are not limited to those listed at http://www.healthcare.gov/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 http://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 http://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) Routine pediatric dental care

Preventive pediatric dental care for dependent children through age 12 for the following procedures:

(i) One (1) complete initial oral exam by child's dentist;

(ii) One (1) periodic oral exam per person, twice per Calendar Year;

(iii) One (1) cleaning per person, twice per Calendar Year;

(iv) One (1) fluoride treatment per person, twice per Calendar Year; and

(v) Bitewing x-rays, twice per Calendar Year.

(3) Vision Care

(a) Routine vision exam excluding contact lens fittings

(b) Vision eyewear for special conditions:

Includes coverage for contact lenses or eyeglasses needed for the following conditions:

(i) Keratoconus. One pair of contact lenses is covered per Calendar Year. The replacement of lenses, due to a change in the Covered Person's condition, is limited to 3 per affected eye per Calendar Year.

(ii) Post-cataract surgery with an intraocular lens implant (pseudophakes). Coverage is limited to $140 per surgery toward the purchase of eyeglass frames and lenses. The replacement of lenses due to a change in the Covered Person's prescription of .50 diopters or more within 90 days of the surgery is also covered up to a limit of $140.

(iii) Post-cataract surgery without lens implant (aphakes). One pair of eyeglass lenses or contact lenses is covered per Calendar Year. Coverage up to $50 per Calendar Year is also provided for the purchase of eyeglass frames. The replacement of lenses due to a change in the Covered Person's condition is also covered. Replacement of lenses due to wear, damage, or loss is limited to 3 per affected eye per Calendar Year.

(iv) Post-retinal detachment surgery. For a Covered Person who wore eyeglasses or contact lenses prior to retinal detachment surgery, the Plan covers the full cost of one lens per affected eye up to one Calendar Year after the date of surgery. For Covered Persons who have not previously worn eyeglasses or contact lenses, the Plan covers eyeglass lenses up to $50 toward the purchase of the frame or pair of contact lenses.

(4) Physician Services

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

(b) Anesthesia (Inpatient/Outpatient)

(c) Chiropractic services from a licensed provider

(d) Maternity

Includes delivery, prenatal, and postpartum care of mother and fetus.

Amniocentesis is included for women age thirty-five (35) and older.

(e) Physician Hospital visits

Medical diagnosis, care and/or treatment provided by a doctor or legally licensed Physician including Hospital inpatient care, Hospital outpatient visits/exams and clinic care

(f) Physician office visits

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

(g) 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.

(h) 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 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 (who are not in the network but otherwise covered, such as emergency medical care and urgent care received outside the service area): 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.

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

(5) Hospital Services – Inpatient

(a) Hospital room & board

Hospital room and board for a semiprivate room, intensive care unit, cardiac care unit or burn care unit, but excluding charges for a private room (unless determined to be Medically Necessary) which are in excess of the Hospital's semiprivate room rate. Charges made by a Hospital having only private rooms will be considered at 80% of the private room rate (i.e., 20% of the charge for private room will be excluded before benefits are determined).

(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.

No authorization from the Plan need be sought by the attending Physician for prescribing a length of inpatient stay for the mother or newborn not in excess of 48 hours (or 96 hours, for a cesarean section). The 48- or 96-hour limit may be exceeded with precertification in cases of Medical Necessity.

(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 for either 48 hours following a vaginal delivery, or a minimum of 96 hours following a cesarean section, 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. In addition, all reasonable and necessary transportation, lodging and meal expenses incurred during the Transplant Benefit Period will be covered.

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

(g) Charges for cosmetic purposes or for cosmetic surgery are covered only 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) Outpatient department

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

(e) Preadmission testing

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

(f) Student Health Centers

(g) Urgent care facility/walk-in clinic

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

(9) Mental Health/Substance Use Disorders

Inpatient confinement or Partial Hospitalization/Intensive Outpatient Treatment for the treatment of a mental Illness in a licensed general Hospital, in a mental Hospital under the direction and supervision of the Department of Mental Health,

or in a private mental Hospital licensed by the Department of Mental Health, or confinement or Partial Hospitalization/Intensive Outpatient Treatment in a public or private substance use disorder facility.

Outpatient treatment of Mental Health Disorders and outpatient treatment of substance use disorders on an outpatient basis provided services are furnished by a:

(a) Comprehensive health service organization;

(b) Licensed or accredited Hospital;

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

(d) Licensed detoxification facility;

(e) Licensed social worker;

(f) Psychologist; or

(g) Psychiatrist

(10) Other Services and Supplies

(a) Ambulance services:

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

When Medically Necessary, from a Hospital; or

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

(b) Autism Spectrum Disorders treatment

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) Breast reduction surgery when deemed to be Medically Necessary

(e) Cardiac rehabilitation

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

(f) Chelation therapy for treatment of heavy metal poisoning

(g) Chemotherapy and radiation therapy

(h) Clinical Trials - Routine services for Approved Clinical Trials

Routine costs for items and services furnished in connection with participation in Approved Clinical Trials are covered at the same level as the same services provided outside Approved Clinical Trials, including Hospital visits, imaging and laboratory tests if:

(i) the referring health care professional is a participating health care provider and has concluded that the individual's participation in such trial would be appropriate, or

(ii) the participant or beneficiary provides medical and scientific information establishing that the individual's participation in such trial would be appropriate, and

(iii) these services are Covered Services under the Plan

(i) Cochlear implants

(j) Dental/oral services (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; and

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

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.

See the section titled "Schedule of Medical Benefits" for any Plan limitations.

(k) Diabetes self-management training and education

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

(l) Diagnostic imaging (MRI, CT scan, PET scan)

(m) Diagnostic x-ray and laboratory

X-ray, microscopic tests, laboratory tests, including electro-cardiograms, electroencephalograms, pneumoencephalograms, basal metabolism tests, or similar well-established diagnostic tests generally approved by Physicians throughout the United States.

(n) Dialysis/Hemodialysis

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

(o) 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), neuromuscular stimulators including TENS units and related supplies, and other durable medical or surgical equipment.

(p) 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.

(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 Services for BRCA testing

(t) Hearing aids

(u) 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;

(iv) Services of a medical social worker; and

(v) 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.

(v) 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.

(w) Infertility treatment

Treatment of infertility including medicines and surgical procedures

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

(y) Marital counseling when rendered by a licensed provider

(z) 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 Nutramigen, Alimentum, or Neocate are covered.)

(aa) Methadone maintenance and treatment

(bb) 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.

(cc) 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

(dd) 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, Injury, or developmental delay, or in a freestanding duly licensed outpatient therapy facility

(ee) Orthotics (excluding foot orthotics, except for treatment of severe diabetic foot disease)

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; head halters; and specially molded orthopedic shoes and/or orthotic inserts for Covered Persons with severe diabetic foot disease.

(ff) Oxygen and other gasses and their administration

(gg) 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, Injury, or developmental delay, or in a freestanding duly licensed outpatient therapy facility.

(hh) 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.

(ii) Prosthetics

Prosthetic appliances such as artificial arms and legs including accessories; larynx prosthesis; eye prosthesis; breast prosthesis (made necessary due to

breast removal arising from Illness or Injury), 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.

(jj) 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.

(kk) Respiratory 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

(ll) 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.

(mm) Sleep disorders

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

(nn) 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, Injury, or developmental delay when precertified. If speech loss is due to a congenital anomaly, surgery to correct the anomaly must have been performed prior to therapy.

(oo) 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.

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

(qq) Voluntary sterilization

(rr) Voluntary termination of pregnancy

(ss) Wigs

Wigs for hair loss resulting from the treatment of cancer or other serious medical condition, trauma, Injury, or alopecia areata/totalis. 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) Fitness reimbursement benefit

Reimbursement will be made for health club membership fees. Membership fees must be paid in the current Calendar Year for membership in that year, and the paid date must be within the Covered Person's dates of enrollment in this Plan

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) Physician travel or transportation expenses or broken appointments, except for benefits specifically stated as covered under the Plan

(4) Amounts in excess of the Contracted Rate for In-Network Providers, or if not in the network but otherwise covered, in excess of the Allowed Amount

(5) 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

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

(7) 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

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

(9) 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

(10) Services, supplies and treatment which a Covered Person is entitled to receive without charge from any municipal, state or federal program. This exclusion does not apply when otherwise prohibited by law, including laws applicable to Medicaid and Medicare

(11) 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

(12) 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

(13) 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)

(14) 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

(15) 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

(16) 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

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

(18) 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.

(19) Acupuncture therapy

(20) Biofeedback

(21) Childbirth classes

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

(23) 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."

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

(25) Erectile dysfunction treatment, except medication covered under the Prescription Drug Benefit

(26) Eyewear, routine (including lenses, frames and contact lenses, and their fitting)

(27) Fluoride and fluoride varnish, for Covered Persons age 6 and older

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

(29) Foot orthotics, shoe inserts or orthopedic and corrective shoes (except when part of a leg brace or to treat diabetic conditions)

(30) Gender Dysphoria Treatment excludes the following services: face-lifting, lip reduction/ enhancement, blepharoplasty, laryngoplasty (or other voice modification surgery), facial implants or injections, silicone injections of the breast, liposuction, electrolysis, hair removal, or hair transplantation, collagen injections, removal of redundant skin and reversal of gender reassignment surgery and all related drugs and procedures related to the reversal

(31) Growth hormones, except for medication covered under the Prescription Drug Benefit

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

(33) Learning disabilities or behavioral problems, except for benefits specifically stated as covered

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

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

(36) "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

(37) Pain management programs/clinics

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

(39) 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

(40) Planned home births

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

(42) Private duty nursing

(43) Sex therapy

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

(45) Visual refraction surgery, including radial keratotomy

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

(47) Weight loss programs

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility

Employees and their Eligible Dependents are eligible to participate in the Plan as determined by the Plan Sponsor.

Employees should contact the Plan Sponsor for a description of eligibility guidelines that apply to him or her and their Eligible Dependents, as well as effective dates of coverage.

B. Enrollment

To enroll in this Plan, an Employee must elect coverage during an applicable enrollment period. 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. The Plan Administrator determines the times when an Employee may enroll or change a current election under this Plan and, the applicable enrollment/election deadlines.

Enrollment/Election Periods

Enrollment/Election Due To:	Enrollment/Election Deadline:
1. Initial Eligibility Period	The time period following completion of Waiting Period as determined by the Plan Sponsor.
2. Open Enrollment Period	The last day of the annual enrollment period specified by the Plan Sponsor
3. Qualified Change in Status	Thirty (30) days after the date of the Qualifying Change in Status*
4. Special Enrollment Period following a gain or loss of eligibility for Medicaid or CHIP	Sixty (60) days after the date of the loss or gain of eligibility for Medicaid or CHIP
5. HIPAA Special Enrollment Period ***a. Following loss of other coverage or*** ***b. Acquisition of Eligible Dependent***	Thirty (30) days after the date of the loss of other coverage or acquisition of Eligible Dependent*

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

(1) Initial Eligibility Period

An Employee may elect to enroll in this Plan during the time period following completion of the Employee's Waiting Period as determined by the Plan Sponsor. 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 period described below. For subsequent Plan Years, an Employee may change his or her election during the open enrollment period.

(2) Open Enrollment Period

During open enrollment periods held on dates determined by the Plan Administrator, an Employee may change elections with respect to enrollment in this Plan for the Employee, and/or Eligible Dependents. In the absence of an affirmative election during an open enrollment period, an eligible Employee's election with respect to participation in this Plan which is in effect as of the last day of the Plan Year will automatically carry over for the following Plan Year.

(3) Qualified Change in Status

An Employee may change an election with regard to coverage under this Plan after the initial eligibility period and outside an 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.

(4) Special Medicaid/CHIP Enrollment Period

If an Employee is not covered under this Plan, or is covered but has not enrolled any Eligible Dependents, the Employee may elect to enroll and may elect to enroll any Eligible Dependents if:

(a) 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

(b) 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.

(5) HIPAA Special Enrollment Period Following Involuntary Loss of Other Coverage or Acquisition of Eligible Dependent

(a) 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 or herself and any of his or her Eligible Dependents if all the conditions below are met:

(i) The Employee declined coverage under the Plan for the Employee and any Eligible Dependents when it was offered previously;

(ii) 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;

(iii) 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.

(iv) 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.

(b) 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:

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

(ii) 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.

C. Participation

The Plan Administrator determines when participation begins or ends based on a permitted election. 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 date established by the Plan Sponsor for new hires reasonably expected to average the sufficient number of hours of service per week under Section A above	Begins on the later of: ▪ The date the Employee's coverage begins, if Eligible Dependents were enrolled on or before that date, or ▪ The date of enrollment
2. Open Enrollment Period	Begins or ends, as applicable, on the first day of the 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.

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

In all cases where an Employee is eligible and elects to continue coverage during periods of absence from work as described below, the Employer's obligation to provide ongoing coverage under this Plan ceases if the Employee is more than thirty (30) days late in making the required contributions.

(a) 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:

(i) The expiration of the leave, or

(ii) 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.

(b) 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.

(c) Other Approved Leave of Absence (other than FMLA Leave or Military Service)

A covered Employee may continue to participate in this Plan during an approved leave period, beginning from the date last worked, provided the Employee continues the necessary contributions. If the Employee does not return to an Actively at Work status upon expiration of the approved leave period, or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

(d) Disability (other than under FMLA Leave)

A covered Employee who is absent from work and who is Totally Disabled as defined under this Plan (other than under FMLA Leave), may continue to participate in this Plan for a period consistent with the Employer's policy, subject to payment of the necessary contributions. If the Employee does not return to an Actively at Work status after expiration of the approved period or does not continue the necessary contributions, coverage under the Plan will be terminated and continuation of coverage under COBRA will be offered.

(2) Participation for Employees under Compensation Maintenance Agreements, Retirement Agreements, and/or Severance Agreements

Employees who enter into special written agreements with the Employer are eligible to continue participation in the Plan following termination of employment as specified under the terms of each individual's agreement. In each such case, coverage following termination of employment continues for the period specified under the terms of each individual's agreement, and then continuation of coverage under COBRA will be offered.

(3) Participation in Cases of Return to Work or Reemployment

(a) 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 determined by the Plan Sponsor.

(b) 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 that the Employee is eligible for coverage upon return in accordance with the provisions established by the Plan Sponsor, and the Employee returns to Actively at Work status:

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

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

(iii) 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.

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

In each other case of reemployment or return to eligible status from ineligible status, the Covered Person will become covered upon the Employee's return to Actively at Work full-time status in accordance with the provisions established by the Plan Sponsor.

(d) Reemployment While Covered under COBRA

Participation in the Plan will begin immediately for any former enrolled Employee and any 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 established by the Plan Sponsor.

(e) Reemployment in General

Participation in the Plan will be in accordance with the provisions established by the Plan Sponsor for any former enrolled Employee and their Eligible Spouse and Dependents if the Employee is rehired within thirteen (13) weeks of termination of employment (otherwise referred to as a Break-in-Service). In the case of an Employee rehired within thirteen (13) weeks of termination who had not satisfied the Waiting Period as of the termination date, the Waiting Period will be reduced by the period of prior employment.

In each other case of reemployment beyond a thirteen (13) week period or return to eligible status from ineligible status, the Covered Person will become covered upon the Employee's return to Actively at Work full-time status in accordance with the provisions established by the Plan Sponsor.

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; or

(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 Employee will be deemed to have full no-fault coverage to the maximum available in that state, whether or not the Employee 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 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 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.

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 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.

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

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

I. Medicare and Medicaid Reimbursements

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

J. Right to Receive and Release Necessary Information

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

K. Facility of Payment

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

L. Right of Recovery

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

IX. PLAN ADMINISTRATION

A. Plan Administrator

The Plan Administrator will be appointed by the Employer.

B. Allocation of Authority

Except as to those functions reserved by the Plan to the Employer or the Board of Directors of the Employer or the PACE, 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 or the PACE 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 Plan Summary, 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. Notwithstanding the foregoing; the Plan Administrator has delegated to the PACE discretion, control and exclusive duty and authority to determine what constitutes a covered benefit under the Plan for claims payment or denials pertaining to second level appeal determination for post-service claims as in accordance with the terms and provisions set forth under Article VI of this Plan entitled "Claims and Appeals Procedures and Statement of ERISA Rights."

(2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan, or to delegate such responsibility to the PACE regarding second level appeal determination for post-service claims under the Plan.

All determinations of the Plan Administrator or the Board of Directors or the PACE, as applicable, 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 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, or to delegate such responsibility to the PACE regarding second level appeal determination for post-service claims under 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 Person 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.

When the Plan Administrator assigns the PACE the task of making a determination regarding second level appeals for post-service claims, the PACE shall possess the rights and exercise the duties otherwise ascribed to the Plan Administrator only insofar as it relates to said second level appeals for post-service claims. Assignment is achieved by and when the Plan Administrator advances a request for a second level appeal for a post-service claim, received by the Plan or its authorized agent(s), to the PACE with instructions to provide a directive regarding such appealed claim.

E. Fiduciary Liability

The Plan Administrator is the named fiduciary under the Plan except as to the fiduciary duties extended to the PACE.

The PACE's fiduciary duties extend only to those determinations actually made by the PACE, and with which the Plan Administrator complies. The PACE may perform other tasks on behalf of, and in consultation with, the Plan Administrator, but not as the PACE, and the PACE shall only be deemed to be a fiduciary when making final determinations regarding plan coverage and claims examined via second level post-service appeals. The PACE shall not have fiduciary duties in all other matters, including, but not limited to, other appeals that are not second level post-service appeals, and matters the Plan Administrator is prohibited from referring to the PACE in accordance with applicable law and/or pre-existing contract.

The PACE shall at all times strictly abide by, and make determination(s) in accordance with, the terms of the Plan and applicable law. In instances where the Plan Administrator delegates fiduciary authority to the PACE to make a determination regarding a second level post-service appeal, the PACE shall have discretion to interpret the terms of this Plan, and the PACE possesses all duties and rights otherwise ascribed to the Plan Administrator, for this purpose, in this limited scope only. In such instances, the PACE's determinations will be final and binding on all interested parties, and failure to comply with said determination by the Plan Administrator, shall absolve the PACE of any and all fiduciary (and other) liability, responsibility, obligations, and/or duties.

F. Indemnification and Exculpation

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

G. Compensation of Plan Administrator

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

H. Bonding

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

I. Payment of Administrative Expenses

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

X. TERMINATION AND CONTINUATION OF COVERAGE

A. Termination of Coverage

(1) Termination Events

Participation in and coverage under this Plan for any Employee and his or her Eligible Dependents terminates in accordance with the provisions established by the Plan Sponsor.

Employees should contact the Plan Sponsor for termination provisions that apply to them and their Eligible Dependents.

(2) 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 an Employee's or dependents' 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.

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 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.

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 considered Qualified Beneficiaries.

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

(2) Qualifying Events

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

(a) The death of a covered Employee

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

(c) The divorce or legal separation of a covered Employee from the Employee's Spouse

(d) A covered Employee'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)

If the Qualifying Event causes the covered Employee, or the Spouse or an Eligible Dependent child of the covered Employee, to cease to be covered under the Plan under the same terms and conditions as in effect immediately before the Qualifying Event, 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.) 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 on behalf of the Employee or on behalf of 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 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 the revocation of a waiver, 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)

(d) 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)

(e) 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 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 Eligible Dependent who is not a Qualified Beneficiary and who is receiving coverage under the Plan solely because of the Employee's or Eligible Dependent'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 Eligible Dependent 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 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.

(d) 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 a Qualified Beneficiary 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 maximum coverage 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, 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 within 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 Continuation 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 Continuation 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 of 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 required contribution is 102% of the cost of coverage.

XI. HIPAA PRIVACY AND SECURITY PROVISIONS

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

- Director of Benefits
- Employees and other workforce members at the direction of the above listed classes of employees
- Senior Benefits Analyst
- Benefits Specialist
- Benefits Wellbeing Specialist

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

Security Provisions

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

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

- Require that any agent or subcontractor of the Plan Sponsor agrees to the same requirements that apply to the Plan Sponsor under this provision;

- Report to the Plan any security incident that the Plan Sponsor becomes aware of; and

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

XII. THIRD PARTY RECOVERY, SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

(1) The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an Injury, Illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Covered Person, 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). 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(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. 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;

(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 Plan Summary/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 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 any other person. Neither an Employee nor a beneficiary of an Employee 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 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 or Eligible Dependent.

F. Interests not Transferable

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

G. Severability

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

H. Headings

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

I. Applicable Law

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

J. Limitations on Actions

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

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

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

Overview

The Plan Administrator has delegated the administration of claims processing under the Plan to the Claim Administrator. As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, makes initial claim and initial appeal determinations based on the specific terms of the Plan. Except for those duties delegated to the PACE by the Plan Administrator regarding second level post-service claims as further detailed in this Section, 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 Plan Summary).

(2) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Person within the period specified for the type of claim filed (see *D. Initial Claim Determination*, and Chart A, below).

(3) If the claim is denied in whole or in part, and the Covered Person disputes the determination, he or she may contact the Claim Administrator, or for prescription drugs the Prescription Benefit Manager, to confirm that the claim was properly processed. The Covered Person may also immediately file a formal internal appeal (see *F. Internal Appeals and External Review of Denied Claims,* below). In cases of Urgent Care Claim denials based in whole or in part on medical judgment, the Covered Person may also request a simultaneous external review.

(4) As directed by the Plan Administrator, the Claim Administrator, or for prescription claims the Prescription Benefit Manager, will review the first internal appeal and will make an appeal determination based on the specific terms of the Plan within the period specified for the type of claim that is the subject of the appeal (see *F. Internal Appeals and External Review of Denied Claims*, Chart B below). In cases of Urgent Care Claim denials based on medical judgment for which an expedited external review has been requested, the Independent Review Organization (IRO) will issue a determination.

(5) If the first internal appeal is denied, the Covered Person may file a second internal appeal with the Claim Administrator, or for prescription claims the Prescription Benefit Manager, within the time periods specified in Chart B, below. The appeal will be reviewed by either (1) the PACE, who holds the authority to make the final determination about benefits payable under the Plan pertaining to second level appeal determinations for post-service claims, or (2) the Plan Administrator, who holds the authority to make the final determination pertaining to benefits payable under the Plan for second level appeal determinations for all other types of claims. The second appeal is the final internal appeal available under the Plan.

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

A. Who May File a Claim

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

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

B. Types of Claims

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

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

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

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

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

C. When and How to File a Claim

A Covered Person must submit, or ensure that his or her provider submits, an initial claim for inpatient benefits 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* may be submitted verbally by calling the Claim Administrator at (844) 926-2262 or by any method available for Non-Urgent Care Claims and Post-Service Care Claims.

(2) *Non-Urgent Care Claims* and *Post-Service Claims* may be filed electronically or using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:

- Electronically
- U.S. Mail
- Hand delivery
- Facsimile (FAX): (508) 329-4812

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

D. Initial Claim Determination

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

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

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

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

E. How Claims are Paid

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

F. Internal Appeals and External Review of Denied Claims

If a claim is denied in whole or in part, a claimant may file an internal appeal of the adverse benefit determination. An adverse benefit determination includes a "rescission" (retroactive termination) of an individual's coverage under the Plan due to fraud or intentional misrepresentation. Before filing an appeal, a claimant may first want to contact the Claim Administrator for medical claims or the Prescription Benefit Manager for prescription drug claims at the phone number(s) as shown below in (3) *How and Where to Submit Appeals* to verify that the claim was correctly processed under the terms of the Plan, however, he or she is not required to do so (as shown below in (3) *How and Where to Submit Appeals*).

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

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

(1) *Urgent Care Claim appeals or requests for external review* may be submitted verbally or in writing by calling or faxing the Claim Administrator for medical claims or verbally by calling the Prescription Benefit Manager for prescription claims as shown below in (3) *How and Where to Submit Appeals.* Upon request, Urgent Care Claim appeals based on a medical judgment may be submitted for external review simultaneously with the initial appeal.

(2) *Non-Urgent Care Claim appeals or requests for external review,* and *Post-Service Care Claim appeals or requests for external review* must be in writing and must be submitted to the Claim Administrator for medical claims. Call the Prescription Benefit Manager for prescription appeals as shown below in (3) *How and Where to Submit Appeals*.

(3) How and Where to Submit Appeals

Urgent Care Claim appeals, Non-Urgent Care Claim appeals and Post-Service Care appeals or requests for external review may be submitted to the Claim Administrator or the Prescription Benefit Manager using one of the following methods:

Medical Appeals	
Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581 (844) 926-2262 **Mailing Address:** Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581	**Method:** ▪ U.S. Mail ▪ Hand delivery ▪ Facsimile (FAX):(508) 329-4812
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.	

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

(1) The patient's name

(2) The patient's Plan identification number

(3) 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)

(4) A statement that the Covered Person (or authorized representative on behalf of the Covered Person) is filing an appeal or request for external review

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

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

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

If the initial appeal is denied, the claimant will be given the specific reasons for the denial, with reference to the applicable Plan provision, rule, guideline, protocol or criteria upon

which the denial was based. In the event that an initial appeal is denied, the claimant will have 60 days to request a second appeal. In filing a second appeal, the claimant must follow the procedures specified under (a)-(d) above, and will have the same rights as specified for the initial appeal. The second appeal for urgent care, concurrent care and pre-service care claims 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 for such claims. The second appeal for post-service care claims will be reviewed by the PACE who holds authority under the Plan to make factual findings and to interpret Plan provisions regarding the payment of benefits for such claims**.**

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

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

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

CHART B – Time Limits Regarding Initial and Internal Second Appeals and Request for External Review						
Type of Claim	**Maximum period for Claimant to file initial internal appeal after initial denial**	**Maximum period for issuing determination regarding initial appeal**	**Maximum period for Claimant to file second internal appeal following denial of initial appeal in whole or in part**	**Maximum period for issuing determination regarding second appeal**	**Maximum period for Claimant to file request for external review following denial of final appeal***	**Maximum period for issuing determination regarding external review**
URGENT CARE CLAIMS (including Urgent Concurrent Care Claims)	180 days	72 hours for both initial determination and expedited external review, if eligible and requested	60 days	72 hours	4 months	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CARE CLAIMS	180 days	15 days	60 days	15 days	4 months	45 days
POST-SERVICE CARE 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 Plan Summary. 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 Plan Summary 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 be able to request an external review or file suit in a state or federal court after exhausting the internal appeals 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 the Plan does not adhere to the procedural standards for claims and appeals described under this Article in a manner which is compliant with the Patient Protection and Affordable Care Act. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

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

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.