



Health Plans, Inc.

Plan Document and Summary Plan Description



Health and Welfare Trust Fund of the International Union of Operating Engineers (Local 877) Medicare Supplement Plan (AES Retirees)

Effective: January 1, 2011

**HEALTH & WELFARE TRUST FUND OF THE INTERNATIONAL
UNION OF OPERATING ENGINEERS (LOCAL 877)
SUMMARY OF MATERIAL MODIFICATIONS**

The Medical Benefit Plan(s) offered by Health & Welfare Trust Fund of the International Union of Operating Engineers (Local 877) and administered by Health Plans, Inc. are amended to include coverage related to the testing and treatment of COVID-19 described below, as well as to include continued coverage under the Plan(s), in accordance with the terms of the Coronavirus Aid, Relief, and Economic Stimulus (CARES) Act. The provisions below are in addition to and supersede any contrary provisions detailed in the Plan Document(s) and/or Summary Plan Descriptions.

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

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

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

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

- Coverage of COVID-19 treatment services received via telehealth services or as outpatient services with cost sharing waived. **Effective March 18, 2020**
- Coverage of COVID-19 preventive care and/or vaccinations that may become available with cost sharing waived within 15 days of recommendation for such services issued by either the United States Preventive Services Task Force (USPSTF) or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. **Effective March 27, 2020.**
- Coverage of COVID-19 treatment for inpatient services with cost sharing waived. **Effective March 31, 2020.**

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.**

**HEALTH & WELFARE TRUST FUND OF THE INTERNATIONAL
UNION OF OPERATING ENGINEERS (LOCAL 877)
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.

RECEIPT OF PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

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

Operating Engineers (Local 877 – AES Retirees)

Retiree Name (Please Print)

Retiree Signature

Date

INDEX

I.	ESTABLISHMENT OF PLAN.....	1
II.	GENERAL INFORMATION	2
III.	DEFINITIONS	4
IV.	SCHEDULE OF MEDICAL BENEFITS	12
V.	MEDICAL BENEFITS	24
VI.	MEDICAL LIMITATIONS AND EXCLUSIONS.....	38
VII.	ELIGIBILITY, ENROLLMENT AND PARTICIPATION.....	41
VIII.	COORDINATION OF BENEFITS.....	42
IX.	PLAN ADMINISTRATION	45
X.	TERMINATION AND CONTINUATION OF COVERAGE	48
XI.	HIPAA PRIVACY AND SECURITY PROVISIONS.....	49
XII.	SUBROGATION AND REIMBURSEMENT PROVISIONS	52
XIII.	AMENDMENT AND TERMINATION OF PLAN	57
XIV.	GENERAL PROVISIONS	58
XV.	CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS	60

I. ESTABLISHMENT OF PLAN

THIS INSTRUMENT established by Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 (hereinafter the "Trust Fund") on this 1st day of January, 2011 sets forth the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 Medicare Supplement Plan (AES Retirees) effective as of January 1, 2011.

- A. **E**stablishment of Plan. The Trust Fund hereby sets forth its group health plan known as the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 Medicare Supplement Plan (AES Retirees) (the "Plan"). The Plan is written for the sole and exclusive purpose of providing to the Eligible Retirees and their Eligible Dependents medical and prescription drug benefits as described herein. These benefits have been established by the Trust Fund and are provided on a self-funded basis. As such, the benefits are directly funded through and provided by the Trust Fund, and the Trust Fund has the sole responsibility and liability for payment of benefits under this Plan. Health Plans, Inc. is not the issuer, insurer, or provider of your benefits.
- B. **E**ffective Date. The Plan as described herein is effective as of January 1, 2011.
- C. **A**pplicable 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.

II. GENERAL INFORMATION

Plan Name: Health & Welfare Trust Fund of the International Union of the Operating Engineers Local 877 Medicare Supplement Plan (AES Retirees)

Type of Plan: Health & Welfare plan providing medical and prescription drug benefits on a self-funded basis

Effective Date: January 1, 2011

Employer/Plan Sponsor: Health & Welfare Trust Fund of the International Union of the Operating Engineers Local 877
89 Access Road
Unit 4
Norwood, MA 02062-5233
(781) 769-5789

Trustees of the Plan: Allen R. McWade

Anthony D. Pisano

Plan Number: 501

Trust Fund Identification Number: 04-2624972

Group Number: 001AB9

Plan Administrator: Employer (see above)

Claim Administrator: Health Plans, Inc.
1500 West Park Drive, Suite 330
Westborough, MA 01581
<https://www.healthplansinc.com>
(800) 532-7575

Prescription Benefit Manager: **Retail Card Program and Mail Order Program -**
Express Scripts
1400 Riverport Drive
Maryland Heights, MO 63043
(800) 524-4491

Mail Order Program (for diabetic supplies only) -
New England Mail Order Pharmacy
2 Maple Street
Middlebury, VT 05753
(888) 778-8667

Case Management Services: Care Management Services
P.O. Box 663
Westborough, MA 01581
(866) 325-1550

Agent for Service of Legal Process: Health & Welfare Trust Fund of the International
Union of Operating Engineers Local 877
89 Access Road
Unit 4
Norwood, MA 02062-5233
(781) 769-5789

Source of Contributions: Payments made to the Trust by individual Employers under the provisions of collective bargaining or participation agreements, Retiree contributions, and any income earned from investment of Employer and Retiree contributions. Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular Employer or Retiree organization contributes to the Fund, and if so, the Employer or Retiree organization's address. Retirees may also receive, upon written request, a complete list of Employers and Retiree organizations who contribute to the Fund, and a copy of any applicable collective bargaining or participation agreement(s). All monies are used exclusively for providing benefits to the eligible Retiree/Retirees and their dependents, and for paying all expenses incurred with respect to operating the Plan.

Plan Year Ends: October 31st

Fiscal Year Ends: October 31st

Loss of Benefits: The Trust Fund may terminate the Plan at any time or change the provisions of the Plan by a written instrument signed by the Trust. Your consent is not required to terminate or change the Plan.

Coverage otherwise ends as described in Article X. Termination and Continuation of Coverage. Contact the Trust Fund to discuss what benefit extensions may apply or what arrangements may be made to continue 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.

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

Coinsurance – the percentage of coverage provided by the Plan, after the Covered Person has paid any applicable Deductible or Co-payment. For example, if Coinsurance is 80%, the Plan pays 80% and the Covered Person pays 20%, after any applicable Deductible or Co-payment.

Co-payment – a fixed dollar amount a Covered Person pays for a covered service before any applicable Deductible or Coinsurance amount is applied.

Covered Person – a Retiree or Dependent eligible for benefits and enrolled under this Plan.

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

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

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

Eligible Dependent –

- (1) A Retiree’s* Medicare-eligible opposite-sex lawful spouse.

If spouses are both Retirees*, each can be covered individually or as the Eligible Dependent of the other. Neither can be covered both as a Retiree* and as an Eligible Dependent.

Spouses who become divorced or legally separated for whom the court-ordered terms of the divorce or legal separation requires the Retiree* to provide health coverage remains eligible for coverage until the earliest of:

- (i) The remarriage of the spouse;
- (ii) The remarriage of the Retiree*;
- (iii) The court-ordered termination date of coverage; or
- (iv) The date the Retiree* ceases to be a Covered Person

Retirees* 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 Retiree* will be responsible for any benefit payments made on that dependent's behalf.

*A Retiree's Eligible Dependent is limited to the Retiree's Medicare-eligible spouse, if any, as of the Retiree's initial retirement date.

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.

Employer – means any Employer (including any corporation, partnership or sole proprietorship, or any subdivision or other unit) or Union obligated to contribute to the Fund by reason of a collective bargaining agreement or participation agreement.

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. A drug, device, medical treatment, new technology, procedure or supply will be considered experimental or investigative if:

- (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 a clinical trial, are consistent with that standard of care for someone with the patient's diagnosis, are consistent with the study protocol for the clinical trial and would be covered if the patient did not participate in the clinical trial; or
- (4) Reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, new technology, procedure or supply is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

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

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

- (1) It is primarily engaged in and duly licensed, if such licensing is required, by the appropriate licensing authority to provide skilled nursing services and other therapeutic services.
- (2) It has policies established by a professional group associated with the agency or organization, the professional group must include at least one Physician and at least one Registered Nurse (R.N.) to govern the services provided and it must provide for full-time supervision of such services by a Physician or required licensed or Registered Nurse.
- (3) It maintains a complete medical record on each patient.
- (4) It has an administrator.

Hospice Plan of Care – a prearranged, written outline of care for the palliation and management of a 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. The term “Hospital” will include a residential treatment facility specializing in the care and treatment of alcoholism, drug addiction or chemical dependency, provided such facility is duly licensed, if licensing is required by law in the jurisdiction where it is located, or otherwise lawfully operated if such licensing is not required.

Illness – a sickness or bodily disorder or disease, or mental health disease or disorder. An Illness due to causes which are the same or related to causes of a prior Illness, from which there has not been complete recovery will be considered a continuation of such prior Illness.

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

In-Network Provider – a member of a network of Physicians, other licensed health care providers and/or health care facilities which provide medical services to Covered Persons under this Plan on the basis of a negotiated fee schedule amount. A Covered Person receiving covered services from an In-Network Provider is 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 cause serious harm to bodily functions or any bodily organ or part. Examples of medical emergencies include symptoms of heart attack and stroke; poisoning; loss of consciousness; severe difficulty breathing or shortness of breath; shock; convulsions; uncontrolled or severe bleeding; sudden and/or severe pain; coughing or vomiting blood; sudden dizziness or severe weakness; profound change in vision; severe or persistent vomiting or diarrhea; and profound change in mental status.

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

- (1) Legal and is provided in accordance with generally accepted standards of medical practice
- (2) Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury or disease;
- (3) Not Experimental or Investigational; and
- (4) Not primarily for the convenience of the patient, Physician or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury or disease.

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

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

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

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

Nurse – a professional nurse who has a current active licenses 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 negotiated fee schedule arrangement with this Plan. 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 any amounts in excess of the Reasonable and Customary Charge for the services received, unless specifically stated otherwise in this Plan.

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

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

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

Plan Year – the twelve-month period ending on the date shown in the General Information section.

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

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

Retiree - a former Member who was employed by a Contributing Employer, under the jurisdiction of Local 877, who is eligible for coverage under Medicare Part A (Hospital Insurance) and Medicare Part B (Medical Insurance), and who is enrolled in Medicare Part B and was either:

- (1) (a) At least fifty-five (65) years old at the time of retirement and
(b) Employed with the Employer at least fifteen (15) years at the time of retirement;
or
- (2) Eligible to participate in this Plan following termination of employment per the Retiree’s retirement agreement

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

Significant Break in Coverage – a period of at least 63 consecutive days during all of which a Retiree did not have any Creditable Coverage, not including waiting periods or affiliation periods.

Skilled Nursing Facility – a licensed facility which:

- (1) Provides, for compensation, room and board and 24-hour skilled nursing service under the full-time supervision of a Physician or a Registered Nurse. Full-time supervision means a Physician or Registered Nurse is regularly on the premises at least 40 hours per week.
- (2) Maintains a daily medical record for each patient.
- (3) Has a written agreement of arrangement with a Physician to provide emergency care for its patients.
- (4) Qualifies as an “extended care facility” under Medicare, as amended.
- (5) Has a written agreement with one or more Hospitals providing for the transfer of patients and medical information between the Hospital and convalescent nursing facility.

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

Trust Agreement – means the written agreement between the Union and each Employer establishing and providing for the maintenance of the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 & 70.

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

IV. SCHEDULE OF MEDICAL BENEFITS

This Section contains a summary of the benefits made available under the Plan, as well as important information about how this Plan works. Please also refer to the section titled Medical Benefits for additional information about the benefits coverage and limitations under this Plan.

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

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

Other Questions Regarding Eligibility and Benefits

Please contact the Claims Administrator at 800-532-7575 if you have questions about Plan benefits or eligibility for covered dependents.

PRESCRIPTION DRUG BENEFIT – ADMINISTERED BY EXPRESS SCRIPTS			
Prescription Drug Expense & Mail Order Option <i>New England Mail Order (also known as Vermont Mail Order) can be used for diabetic supplies</i>	<u>Retail Card Program – You Pay</u> (up to a 34 day supply) \$5 Co-payment per generic drug; \$10 Co-payment per brand name drug; <u>Mail Order Pharmacy – You Pay</u> (up to a 34-90 day supply per prescription or refill) \$0 Co-payment per generic drug; \$10 Co-payment per brand name drug;		
Preventive Care approved by Medicare including but not limited to:	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Routine Physical Exam	100%	Nothing	Nothing
Routine Immunizations limited to: <ul style="list-style-type: none"> • Flu shot • Pneumococcal Pneumonia shot • Hepatitis B shot (those at medium to high risk) 	100%	Nothing	Nothing
Routine Lab, X-rays, and Clinical Tests	100%	Nothing	Nothing
Routine Lab, X-rays, and Clinical Tests	100% after Part B deductible and Part B coinsurance	Part B coinsurance and Part B deductible	Nothing

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Preventive Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Colorectal Cancer Screening includes: <ul style="list-style-type: none"> • Routine fecal-occult blood test (1 per calendar year ages 50+) • Routine flexible sigmoidoscopy (1 every 4 years ages 50+) • Routine colorectal cancer screening tests or procedures (including routine colonoscopy -1 every 2 years for high-risk members) • Other routine colorectal cancer screening tests or procedures and changes to tests or procedures according to frequency limits set by Medicare 	100%	Nothing	Nothing
	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Nutritional Counseling for those with: <ul style="list-style-type: none"> • kidney disease who are not on dialysis, • a kidney transplant, or • diabetes 	100% after Part B coinsurance and Part B deductible	Part B deductible and Part B coinsurance	Nothing
Smoking Cessation Counseling	100%	Nothing	Nothing
Routine Gynecological Exam (1 per calendar year for high-risk members and 1 every 2 years all others)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Routine Pap Smears (1 per calendar year)	100%	Nothing	Nothing
Breast Cancer Screening including <ul style="list-style-type: none"> • Routine Mammogram (1 per calendar year) 	100%	Nothing	Nothing

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Preventive Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Hearing Benefit <ul style="list-style-type: none"> Routine Hearing Exam 	Nothing	Full benefit up to a maximum of one (1)* exam per person, every 24 consecutive months. Services must be rendered by a HearUSA, Inc. Provider to be covered.	Nothing
	Nothing	Full benefit up to a maximum of \$1,000 per ear every 5 years when services are rendered by a HearUSA, Inc. provider	Nothing
Routine Prostate Exams and Prostate-Specific Antigen Screening (including 1 PSA test and 1 digital rectal exam per calendar year ages 50+)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Abdominal Aortic Aneurysm Screening (1 per lifetime as part of your one-time “Welcome to Medicare” physical exam)	100%	Nothing	Nothing
Bone Mass Density Testing (up to a maximum of 1 measurement per person every 24 months)	Full benefit	Nothing	Nothing
<u>Vision Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Optometrists Services (for Medicare approved outpatient services to diagnose or treat an illness or injury)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Glaucoma Screening (up to a maximum of 1 per high risk person, every 12 months)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Macular Degeneration Treatment (limitations apply)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Cataract Glasses, Contact Lenses, or Intraocular Lenses (following cataract surgery; up to a maximum of 1 pair following surgery)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing

¹ The Plan does not pay benefits for: any dollar amount above the Medicare approved allowance (unless otherwise stated or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Vision Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Routine Eye Exams (1 exam per calendar year)	Nothing	Full benefit up to a maximum of \$300 per person, per calendar year (combined with eyewear below) (not subject to Reasonable & Customary Charges)	All charges in excess of the \$300 combined routine eye exam and routine eyewear maximum
Lenses/Frames/Contact Lenses (other than post-cataract surgery)	Nothing	Full benefit up to a maximum of \$300 per person, per calendar year (combined with routine eyewear maximum) (not subject to Reasonable & Customary Charges)	All charges in excess of the \$300 combined routine eye exam and routine eyewear maximum
<u>Doctor Services</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Allergy Testing	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Allergy Treatment	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Anesthesia (In/Outpatient)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Chiropractor services (Excludes X-rays)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Physician Hospital Visits	100% after Part B coinsurance and Part B deductible	Part B coinsurance and Part B deductible	Nothing
Physicians Office Visits (also includes other covered professional provider services)	100% after Part B coinsurance and Part B deductible	Part B coinsurance and Part B deductible	Nothing

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Doctor Services</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Podiatrist Services	100% after Part B coinsurance and Part B deductible	Part B coinsurance and Part B deductible	Nothing
Second Surgical Opinion	100% after Part B coinsurance and Part B deductible	Part B coinsurance and Part B deductible	Nothing
Surgery (Inpatient)	100% after Part B deductible and Part B coinsurance	Part B coinsurance and Part B deductible	Nothing
Surgery (Outpatient)	100% after Part B deductible and Part B coinsurance	Part B coinsurance and Part B deductible	Nothing
Surgery (Physician's office)	100% after Part B deductible and Part B coinsurance	Part B coinsurance and Part B deductible	Nothing
<u>Inpatient Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Semiprivate Hospital Room & Board (including surgical services, x-rays, laboratory tests, anesthesia, drugs, medications, intensive care services)			
Days 1-60:	100% after Part A deductible	Part A deductible	Nothing
Days 61-90:	100% after Part A coinsurance	Part A coinsurance	Nothing
60 lifetime reserve days:	100% after Part A coinsurance	Part A coinsurance	Nothing
Day 91-365: (per benefit period after exhausting 60 lifetime reserve days)*	Nothing	100%	Nothing
Day 366+:	Nothing	Nothing	100%
Hospice Services			
• When covered by Medicare	Full benefit for most services	When Medicare does not provide full benefits, the difference between the amount Medicare pays and the allowed charge	Nothing
• When not covered by Medicare	Nothing	Full benefit	Nothing

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

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Inpatient Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Mastectomy and Reconstructive Surgery	100% after Part A deductible	Part A deductible	Nothing
Organ, Bone Marrow, and Stem Cell Transplants	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Surgical Facility & Supplies	100% after Part A deductible	Part A deductible	Nothing
Miscellaneous Hospital Charges	100% after Part A deductible	Part A deductible	Nothing
Skilled Nursing Facility/Rehabilitation Hospital (member must meet Medicare requirements including having been hospitalized for at least 3 days as an inpatient and entering the facility within 30 days of inpatient discharge)			
<u>Facility participating with Medicare**:</u>			
Days 1-20:	100% semiprivate benefit	Nothing	Nothing
Days 21-90	100% semiprivate benefit after Part A coinsurance	Part A coinsurance	Nothing
Days 91-100:	100% semiprivate benefit after Part A coinsurance	Part A coinsurance	Nothing
Days 101+:	Nothing	Nothing	100%
<u>Facility not participating with Medicare**:</u>			
Days 1-90 (benefit is limited to 90 days per illness)	Nothing	Full benefit	Nothing
Days 90+	Nothing	Nothing	100%

**Up to a combined maximum of 100 days per benefit period in a Medicare participating and/or non-participating skilled nursing facility (however, non-participating facilities are limited to 90 days per illness)

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

Outpatient Care	Medicare Pays:	Medicare Supplement Plan Pays¹:	Member Pays²:
Clinic Services	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Continued Active Care -Services provided within the 100 days following a hospitalization which lasted at least 3 days and must be for the purpose of treating the condition which resulted in the hospitalization. Continued Active Care covers outpatient services which include but are not limited to:			
<ul style="list-style-type: none"> • Drugs covered by Medicare Part B including drugs that must be administered by Medicare provider (including home infusion, injectables, chemotherapy), • Medical care service furnished by a Medicare covered provider (including clinic visits, office visits, and home visits), and • Medicare approved short-term rehabilitation therapy 	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Emergency Medical Services includes: <ul style="list-style-type: none"> • Accident treatment • Emergency medical care • Non-medical emergency 	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
	Nothing	Full benefit (after \$25 co-payment per visit)	\$25 co-payment per visit
Hospice Services <ul style="list-style-type: none"> • When covered by Medicare • When not covered by Medicare 	Full benefit for most services	When Medicare does not provide full benefits, the difference between the amount Medicare pays and the allowed charge	Nothing
	Nothing	Full benefit	Nothing
Outpatient Department	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Outpatient Care</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Outpatient Surgery in Hospital, Ambulatory Surgical Center, etc.	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Preadmission Testing	100% after Part A deductible	Part A deductible	Nothing
Urgent Care Facility/Walk-In Clinic	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
<u>Mental Health & Substance Abuse</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Inpatient admission in a general or psychiatric hospital***			
• Days 1-60:	100% after Part A deductible	Part A deductible	Nothing
• Days 61-90:	100% after Part A coinsurance	Part A coinsurance	Nothing
• 60 lifetime reserve days*:	100% after Part A coinsurance	Part A coinsurance	Nothing
• Day 91-365 (per benefit period after exhausting 60 lifetime reserve days)***:	Nothing	Full benefit	Nothing
• Day 366+:	Nothing	Nothing	100%
• Outpatient visits (when visits are covered by Medicare)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
• Outpatient visits (when visits are not covered by Medicare)	Nothing	Full benefit	Nothing

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

*** Coverage for psychiatric hospital admissions is limited to 190 days per lifetime

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

Other Supplies & Services	Medicare Pays:	Medicare Supplement Plan Pays¹:	Member Pays²:
Acupuncture	Nothing	See Alternative/Complementary Care	See Alternative/Complementary Care
Alternative/Complementary Care (Includes, but not limited to, Acupressure, Acupuncture, Homeopathy, Naturopathy, Smoking Cessation, Massage Therapy)	Nothing	Nothing	100%
Ambulance	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Bariatric Surgery	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Blood			
<ul style="list-style-type: none"> Provided to inpatients 	Nothing for first 3 units**** 100% after Part A Blood Deductible for units in excess of 3	Nothing for first 3 units**** Part A Blood Deductible	100%**** Nothing
<ul style="list-style-type: none"> Provided to outpatients 	Nothing for first 3 units**** 100% after Part B Blood Deductible for units in excess of 3	Nothing for first 3 units**** Part B Blood Deductible	100%**** Medicare Blood Processing Copayment
Cardiac Rehabilitation Services must be provided within the 100 days following a hospitalization which lasted at least 3 days and must be for the purpose of treating the condition which resulted in the hospitalization.	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Chemotherapy & Radiation Therapy			
<ul style="list-style-type: none"> Provided to inpatients 	100% after Part A deductible	Part A deductible	Nothing
<ul style="list-style-type: none"> Provided to outpatients 	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing

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

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Other Supplies & Services</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Cochlear Implants when meeting Medicare coverage criteria			
• Hospitalization	100% after Part A deductible	Part A deductible	Nothing
• Audiologist post-operative services	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
• Cochlear implant system	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Dental Services (limitations apply)	100% after Part A deductible	Part A deductible	Nothing
Diabetic Self-Management and Testing Materials			
• Blood Glucose Monitors	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
• Diabetes Self-Management Training Services	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
• Diabetic Testing Materials, Enteral Formulas and Food Products (When covered by Medicare)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
• Diabetic Testing Materials (When not covered by Medicare, including urine test strips)	Nothing	Full benefit	Nothing
Diagnostic Imaging	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Diagnostic X-ray and Laboratory	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

Other Supplies & Services	Medicare Pays:	Medicare Supplement Plan Pays¹:	Member Pays²:
Durable Medical Equipment <ul style="list-style-type: none"> Approved home dialysis or hospice services All other durable medical equipment 	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Enteral Formulas and Modified Low Protein Food Products (When not covered by Medicare)	Nothing	Full benefit	Nothing
Erectile Dysfunction Treatment	Nothing	Nothing	100%
Genetic Counseling, Testing and Related Services	Nothing	Full benefit	Nothing
Hemodialysis	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Home Health Care <ul style="list-style-type: none"> Visits* Durable Medical Equipment 	Full benefit	Nothing	Nothing
	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Injectables	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Marital Counseling	Nothing	Full benefit	Nothing
Neuromuscular Stimulators including TENS for chronic or severe pain following surgery	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Nutritionist (licensed dietician)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing

*Covered by Medicare if meet medical conditions.

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

<u>Other Supplies & Services</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Occupational and Physical Therapy	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Orthotics (orthopedic shoes when an integral part of a leg brace; therapeutic shoes/inserts for diabetics)	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Pain Clinics	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Private Duty Nursing	Nothing	Full benefit	Nothing
Prosthetics	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Pulmonary Therapy	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Sleep Disorders	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Speech Therapy	100% after Part B deductible and Part B coinsurance	Part B deductible and Part B coinsurance	Nothing
Temporomandibular Joint Disorders (TMJ) Treatment	Nothing	Full benefit up to a maximum of \$750 per person, per calendar year	All charges in excess of \$750 per person, per calendar year
Wigs	Nothing	Full benefit up to a maximum of one wig per person, every 5 consecutive years	Nothing
<u>Other Supplies & Services</u>	<u>Medicare Pays:</u>	<u>Medicare Supplement Plan Pays¹:</u>	<u>Member Pays²:</u>
Fitness Reimbursement Benefit (Includes Weight Watchers Weight Loss Plan)	Nothing	Full benefit up to a maximum of \$200 per person and \$400 per family, per calendar year. A paid receipt of the program must be submitted to the Claim Administrator for processing under the provisions of this Plan.	All charges in excess of \$200 per person and \$400 per family, per calendar year.

¹ The Plan does not pay benefits for any dollar amount above the Medicare approved allowance (unless otherwise stated) or any dollar amount above the reasonable and customary charge for services rendered by Out-of-Network Providers (unless otherwise stated).

² The Covered Person is also responsible to pay any amount above the Reasonable and Customary Charge when services are rendered by an Out-of-Network Provider (unless otherwise stated).

V. MEDICAL BENEFITS

A. Covered Expenses

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

(1) Prescription Drugs

Expenses for covered prescription drugs and medicines will be covered as described in the section titled “Schedule of Medical Benefits” through retail pharmacies and Express Scripts’ mail order program.

Diabetic supplies are available through New England Mail Order Program.

The benefits are payable for Medically Necessary prescription drugs ordered in writing by a Physician for treatment of a Covered Person up to a 34-day supply for each prescription or refill (34 – 90-day supply for each prescription or refill through the mail order plan), unless customarily dispensed in 100 unit dose quantities.

Prescription drug charges not covered:

- (a) Drugs dispensed by any person not licensed to dispense drugs;
- (b) Administration of drugs;
- (c) Drugs labeled “Caution Limited by Federal Law for Investigational Use”;
- (d) Drugs administered and consumed at the time and place of the prescription issue;
- (e) Non-legend drugs other than insulin;
- (f) Therapeutic devices or appliances, support garments and other non-medical substances;
- (g) Investigational or experimental drugs; including compounded medications for non-FDA-approved use;
- (h) Prescriptions which an eligible person is entitled to receive without charge from any Worker’s Compensation laws, or any municipal, state or federal program;
- (i) Erectile dysfunction drugs;

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

- (j) Retin A;
- (k) Rogaine

(2) Preventive Care

- (a) Routine physicals
Includes one-time “Welcome to Medicare” physical exam and yearly “Wellness” exam
- (b) Routine immunizations
Includes flu shot, pneumococcal pneumonia shot, and Hepatitis B shot for those at medium to high risk
- (c) Nutritional counseling
For Covered Persons with kidney disease who are not on dialysis or who have had a kidney transplant or have diabetes
- (d) Smoking cessation counseling
- (e) Routine lab, x-rays and clinical tests
Includes certain blood tests, urinalysis, and some screening tests
- (f) Routine colorectal cancer screening
Includes fecal occult screening, sigmoidoscopy, colonoscopy, and/or barium enema
- (g) Routine gynecological care
Includes vaginal cancer screening and cervical cancer screening, including pap smear
- (h) Breast cancer screening
Includes routine mammograms
- (i) Bone density screening
For Covered Persons with certain medical conditions or meeting certain criteria as established by Medicare
- (j) Abdominal aortic aneurysm screening

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

(k) Routine prostate exam
Includes Prostate-Specific Antigen (PSA) screening

(l) Routine hearing exam

(3) Vision Care

- (a) Routine vision exam including contact lens fittings
- (b) Routine eyewear (lenses, frames, and contact lenses)
- (c) Outpatient medical care services furnished by an optometrist to diagnose or treat an illness or injury
- (d) Glaucoma screening for Covered Persons at high risk for glaucoma including diabetics, persons with a family history of glaucoma, and African-Americans age 50 and older
- (e) Macular degeneration treatment for Covered Persons with age-related macular degeneration, limited to ocular photodynamic therapy with verteporfin
- (f) Contact lenses needed to treat keratoconus including the fitting of these contact lenses;
- (g) Cataract glasses, contact lenses, or intraocular lenses following corneal transplant, cataract surgery or other covered eye surgery when the natural eye lens is replaced. Must be provided by an ophthalmologist or an optometrist licensed to provide this service;
- (h) Eye exams for the treatment of any muscle disorders of the eye (e.g. esotropia and strabismus), limited to one office visit or clinic visit per person, per calendar year unless surgery to correct the condition is scheduled. Expenses for muscle training, orthoptics and refractions are not an eligible expense under the provisions of this Plan.

(4) Physician Services

- (a) Allergy testing and treatment, including preparation of serum and injections
- (b) Anesthesia (In/outpatient)
- (c) Chiropractic services from a licensed provider, excluding x-rays
- (e) Physician Hospital visits

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

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

(f) Physician office visits

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

(g) 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. Benefits may include diagnostic lab tests and x-rays, surgery that is an integral part of the treatment of foot injury, other medically necessary foot care such as treatment for hammertoe and osteoarthritis.

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

(h) Second surgical opinion and, in some instances, a third opinion for non-emergency surgery

(i) Surgery (inpatient/outpatient/office)

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

(5) Hospital Services – Inpatient

(a) Semi-private hospital room & board

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

(b) 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.

- (c) Organ transplants – including bone marrow and stem cell transplants

Coverage is available to Covered Persons for organ and/or tissue transplants listed below only:

Human Heart Transplant	Kidney Transplant
Bone Marrow Transplant	Cornea Transplant
Stem Cell Transplant (to treat certain conditions)	Liver Transplant
Heart and Lung Transplant	Pancreas Transplant
Lung Transplant	

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

- (i) Evaluation, screening, and candidacy determination process;
- (ii) Organ transplantation;
- (iii) Organ procurement as follows:

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

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

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

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

- (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..

- (d) 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; or
- (ii) 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.

- (e) Skilled Nursing Facility/Rehabilitation Hospital

Includes semi-private room, meals, skilled nursing and rehabilitative services and other supplies that are medically necessary after a 3-day minimum inpatient hospital stay for a related Illness or Injury. Charges must be incurred within thirty (30) days following a Hospital confinement in a participating Medicare facility or within fourteen (14) days following a Hospital confinement in a non-participating Medicare facility

(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) Continued active care

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

- (c) Emergency Room services

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

- (d) Outpatient department

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

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

- (f) Preadmission testing

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

- (g) Urgent care facility/walk-in clinic

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

(9) Mental Health/Substance Use Disorders

Inpatient and outpatient benefits provided for services to diagnose and treat mental Illness (including drug addition and alcoholism)

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 generally given outside a hospital or in a hospital outpatient setting, including visits with a psychiatrist or other doctor, clinical psychologist, nurse practitioner, physician's assistant, clinical nurse specialist, licensed mental health counselor, or clinical social worker; substance abuse services; and lab tests

(10) Other Services and Supplies

- (a) Ambulance services:

Ground ambulance transportation to a hospital or skilled nursing facility for medically necessary services when transportation in any other vehicle endangers health. Ambulance transportation in an airplane or helicopter to a hospital when immediate and rapid ambulance transportation is needed and cannot be provided by ground transportation. Limited non-emergency ambulance transportation when medically necessary and ordered by a physician.

- (b) Bariatric surgery for the treatment of Morbid Obesity

- (c) Blood

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

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

- (e) Cardiac rehabilitation
Comprehensive programs include exercise, education, and counseling for Covered Persons meeting criteria
- (f) Chemotherapy and radiation therapy
- (g) Cochlear implants
Includes hospitalization, audiologist post-operative services, and cochlear implant system for Covered Persons meeting the coverage criteria
- (h) Dental surgery (limited)
Includes reduction of a dislocation or fracture of the jaw or facial bone; excision of a benign or malignant tumor of the jaw; services by a dentist, surgical day care unit, or ambulatory surgical facility when Medicare determines that a medical condition (ex. hemophilia, heart disease) or the severity of a dental procedure necessitates surgery to be safely performed in a surgical day care unit or ambulatory surgical facility; services when an integral part of either a covered procedure; and extractions in preparation for radiation treatment for neoplastic diseases involving the jaw
- (i) Diabetes self-management training and education
Includes blood glucose testing monitors, blood glucose test strips, urine test strips, lancet devices and lancets, blood glucose control solutions, diabetes self-management training services, diabetes testing materials, and therapeutic shoes (in some cases).
- (j) Diagnostic imaging (MRI, CT scan, PET scan and other diagnostic tests)
- (k) Diagnostic x-ray and laboratory
Outpatient diagnostic laboratory tests, diagnostic x-ray, and other diagnostic tests
- (l) Dialysis/Hemodialysis
Outpatient hemodialysis (renal therapy) for Covered Persons with End-Stage Renal Disease (ESRD) in either a Medicare-approved dialysis center or at home when ordered by a Physician and self-dialysis training services for home dialysis services.

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

(m) Durable medical equipment

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

(n) Genetic counseling, testing and related services

(o) Hearing aids

(p) Home health care

Part-time or intermittent skilled nursing care, or physical therapy, speech-language pathology, or occupational therapy ordered by a certified home health agency. May include medical social services, part-time or intermittent home health aide services, durable medical equipment, and medical supplies for use at home. The Covered Person must be homebound to be eligible for services.

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.

(q) 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;

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

- (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:
 - (xi) 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
 - (xii) Charges for such services are incurred by the Covered Persons within six (6) months of the terminally ill Covered Person's death.
- (r) Injectable medications which must be administered in the outpatient department of a Hospital or in a Physician's office
- (s) Marital counseling when rendered by a licensed provider
- (t) 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.)
- (u) 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.

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

- (v) 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.
- (w) Neuromuscular stimulators including TENS units and related supplies for chronic or severe pain following surgery
- (x) Nutritionist (licensed dietician) – also see Alternative/Complementary Care benefit

Medicare approved outpatient services to treat diabetes or kidney disease or those with a kidney transplant in the prior 36 months
- (y) Occupational therapy

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

For the purpose of treating an Illness or Injury, services and equipment such as orthopedic braces, including leg braces with attached shoes (when an integral part of the brace); arm, back and neck braces; surgical supports; and head halters.

Specially molded shoes and inserts are limited to one (1) pair per person, per calendar year for diabetics with severe diabetic foot disease.
- (aa) Oxygen and other gasses and their administration

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

Portable oxygen is not covered when oxygen is only needed during sleep or when provided only as a backup to a stationary oxygen system
- (bb) Pain management programs/clinics

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

(cc) Physical Therapy

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

(dd) Private duty nursing

Services by a private duty nurse furnished by a registered nurse (R.N.), or licensed practical nurse (L.P.N.), including charges billed by a Visiting Nurse Association, the need for which is substantiated by a written statement by the attending Physician.

Note: Services provided by an immediate member of the Retiree's family or a nurse who resides in the Retiree's home, or provided on a twenty-four (24) hour basis are not covered expenses.

(ee) 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 (limited to two (2) per person, per calendar year) when purchased following a mastectomy. Excludes replacement, repair or adjustment, unless the replacement, repair or adjustment is necessary because of physiological changes or the prosthesis that is being replaced is at least five (5) years old and no longer serviceable.

(ff) Pulmonary therapy

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

(gg) 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.

(hh) Sleep disorders

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

(ii) Speech Therapy

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

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

(kk) Wigs

Wigs for hair loss resulting from the treatment of cancer or other serious medical condition. 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 and for weight loss clinics/programs. 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.

(12) State surcharges on covered benefits paid under the Plan for which the Covered Person is legally liable, to the extent required by law.

VI. MEDICAL LIMITATIONS AND EXCLUSIONS

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

- (1) Any services not covered or approved by Medicare, except for benefits specifically stated as covered.
- (2) Any services paid at 100% of the approved charges by Medicare.
- (3) Expenses incurred prior to the effective date of coverage under the Plan, or after coverage is terminated.
- (4) 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.
- (5) Amounts in excess of the Reasonable and Customary Charges for Out-of-Network Providers.
- (6) 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.
- (7) Experimental or Investigational drugs, devices, medical treatments or procedures as defined in the Article titled "Definitions."
- (8) 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.
- (9) Treatment which is not the result of an Injury or Illness, except for benefits specifically stated as covered under the Plan.
- (10) 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.
- (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.

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

- (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.
- (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) Chelation therapy
- (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

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

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
- (26) Hypnosis, hypnotherapy, homeopathic treatment, Rolfing, Reiki, massage therapy, aromatherapy and alternative medicine, except for benefits specifically stated as covered under this Plan
- (27) Inpatient care in excess of 365 days per benefit period
- (28) Long-term care
- (29) Learning disabilities, behavioral problems, or developmental delay services or treatment
- (30) Medical supplies that are incidental to the treatment received in a physician or other provider’s office or are provided as take-home supplies
- (31) Methadone maintenance and treatment
- (32) Orthoptics and visual therapy for the correction of vision
- (33) “Over-the-counter” drugs or medical supplies which can be purchased without a prescription or when no Injury or Illness is involved, except for benefits specifically stated as covered under this Plan
- (34) Pastoral counseling, music or art therapy (unless part of an inpatient program), assertiveness training, dream therapy, recreational therapy, stress management or other supportive therapies.
- (35) Personal comfort, hygiene or convenience items such as televisions, telephones, radios, air conditioners, humidifiers, dehumidifiers, physical fitness equipment, whirlpool baths, education, or educational aids or training whether or not recommended by a Physician
- (36) Podiatry services for routine care, including care for bunions, corns, calluses, toenails, flat feet, fallen arches and chronic foot strain
- (37) Sex therapy or transsexual surgery and related preoperative and postoperative procedures or complications, which, as their objective, change the person’s sex
- (38) Visual refraction surgery, including radial keratotomy
- (39) Vitamins and food supplements, except for benefits specifically stated as covered under this Plan

See Schedule of Medical Benefits for additional important information about coverage levels and limitations

VII. ELIGIBILITY, ENROLLMENT AND PARTICIPATION

A. Eligibility.

Retirees, and their Eligible Dependents, as defined under this Plan are eligible for coverage.

B. Enrollment.

A Member who terminates employment and is a Retiree as defined under this Plan may elect to enroll for retirement coverage within thirty-one (31) days of retirement. To make an election, all the required enrollment forms must be submitted to the Plan Administrator within thirty-one (31) days from the date of retirement, unless due to administrative error.

C. Participation.

Participation for Retirees begins on the initial eligibility date provided all enrollment materials are submitted by the deadlines shown under Section B, *Enrollment*, above. Participation for Eligible Dependents enrolled by a Retiree begins on the date the Retiree's coverage begins, if the Eligible Dependent was enrolled on or before that date. Coverage and participation under this Plan begin and end on the same date.

VIII. COORDINATION OF BENEFITS

This Medicare Supplement Plan provides benefits to Retirees and their Eligible Dependents age 65 or over, and requires that Covered Persons be entitled to (i.e., enrolled in) Medicare Parts A and B.

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

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

- B. **Maximum Benefits under All Plans.** If any Covered Person covered under this Plan also is covered under one or more Other Plans and the sum of the benefits payable under all the Plans exceeds the Covered Person's eligible charges during any claim determination period, then the benefits payable under all the Plans involved will not exceed the eligible charges for such period as determined under this Plan. Benefits payable under another Plan are included, whether or not a claim has been made. For these purposes (a) "Claim Determination Period" means a calendar year, and (b) "Eligible Charge" means any necessary, reasonable, and customary item of which at least a portion is covered under this Plan, but does not include charges specifically excluded from benefits under this Plan that also may be eligible under any Other Plans covering the Covered Person for whom the claim is made.
- C. **Other Plan.** "Other Plan" means the following plans providing benefits or services for medical and dental care or treatment:
- (1) Group insurance or any other arrangement for coverage, whether on an insured or uninsured basis.
 - (2) Blue Cross, Blue Shield, or any other prepayment coverage, including health maintenance organizations ("HMOs"), Medicare, or Medicaid.
 - (3) Vehicle insurance. When medical payments are available under any vehicle insurance, this Plan shall pay excess benefits only, without reimbursement for vehicle plan and/or policy deductibles. This Plan shall always be considered

secondary to such plans and/or policies. This applies to all forms of medical payments under vehicle plans and/or policies regardless of its name, title or classification. For purposes of this Plan, in states with compulsory no-fault automobile insurance laws, each Covered Person will be deemed to have full no-fault coverage to the maximum available in that state, whether or not the Covered Person is in compliance with the law, or whether or not the maximum coverage is carried.

D. **Determining Order of Payment.** If a Covered Person is covered under two or more health plans in addition to Medicare Parts A and B, benefits will be paid under this Plan as follows:

- (1) If the Covered Person is covered under another group health plan on the basis of the Covered Person's or the subscriber's employment status, the other group health plan will pay first, Medicare will pay second and this Plan will pay third.
- (2) If the Covered Person is covered under another Medicare supplement plan, Medicare pays first and the Plan covering the Person other than as an Eligible Dependent, for example as a member, subscriber, policyholder or retiree, pays second. If the Covered Person is covered under another Medicare supplement plan, Medicare pays first and the Plan covering the Person as an Eligible Dependent pays second, and this Plan pays third.
- (3) If no Plan is determined to have primary benefit payment responsibility, then the Plan that has covered the Covered Person for the longest period has the primary responsibility.
- (4) A Plan that has no coordination of benefits provision will be deemed to have primary benefit payment responsibility.

E. **Facilitation of Coordination.** For the purpose of Coordination of Benefits, the Claim Administrator:

- (1) May release to, or obtain from, any other insurance company or other organization or individual any claim information and any individual claiming benefits under the Plan must furnish any information that the Plan sponsor may require.
- (2) May recover on behalf of the Plan any benefit overpayment from any other individual, insurance company, or organization.
- (3) Has the right to pay to any other organization an amount it will determine to be warranted, if payments that should have been made by the Plan have been made by such organization.

- F. **Enrollment and Provision of Benefits without Regard to Medicaid Eligibility.** In enrolling a Retiree or Eligible Dependent as a Covered Person or in determining or making any payments for benefits of a Retiree as a Covered Person, the fact that the Covered Person is eligible for or is provided medical assistance under a state plan for medical assistance approved under Title XIX of the Social Security Act will not be taken into account.
- G. **Medicare and Medicaid Reimbursements.** The Plan will reimburse the Centers for Medicare and Medicaid Services or any successor government agency for the cost of any items and services provided by Medicare for any Covered Person that should have been borne by this Plan. Similarly, the Plan will reimburse any state Medicaid program for the cost of items and services provided under the state plan that should have been paid for by this Plan.
- H. **Right to Receive and Release Necessary Information.** For the purposes of determining the applicability of and implementing the terms of this Section or any provision of similar purpose of any other plan, the Trust Fund, through its authorized administrator, may, without the consent of or notice to any person to the extent permitted by law, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which is deemed to be necessary for such purposes. Any person claiming benefits under this Plan will furnish such information as may be necessary to implement this provision.
- I. **Facility of Payment.** Whenever payments which should have been made under this Plan in accordance with this provision, have been made under any other plans, the Trust Fund will have the sole right and discretion to pay over to any organizations making such other payments any amounts it will determine to be warranted in order to satisfy the intent of this provision, and amounts so paid will be deemed to be benefits paid under this Plan.
- J. **Right of Recovery.** Whenever payments have been made by the Trust Fund 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 Trust Fund 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 is the Health & Welfare Trust Fund of the International Union of Operating Engineers Local 877 (the “Trust Fund”). The Plan is administered by the Board of Trustees. The Board of Trustees employs a full-time administrator, Louis F. Malzone, who is located at the Fund office, 89 Access Road, Unit 4, Norwood, Massachusetts 02062. A staff assists in the administration of the Fund. The Board of Trustees also has contracted with a third party administrator, Health Plans, Inc., 1500 West Park Drive, Westborough, Massachusetts 01581, to perform claims administration for medical claims.
- B. **Allocation of Authority.** Except as to those functions reserved by the Plan to the Trust Fund or the Board of Trustees of the Trust Fund, 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 Trustees by the Plan or that the Board may reserve to itself) have the sole and exclusive right and discretion:
- (1) To interpret the Plan, the Summary Plan Description, and any other writings affecting the establishment or operation of the Plan, both as to legal import and as to the application of the provisions of any such documents to the facts of a particular claim for benefits, and to decide all matters arising under the Plan, including the right to remedy possible ambiguities, inconsistencies, or omissions.
 - (2) To make factual findings and decide conclusively all questions regarding any claim for benefits under the Plan.

All determinations of the Plan Administrator or the Board of Trustees 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; to inform the Trust Fund, as appropriate, of the amount of such Benefits; and to provide a full and fair review

to any covered individual whose claim for benefits has been denied in whole or in part.

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

- D. **Delegation by the Plan Administrator.** The Plan Administrator may employ the services of such persons (including an insurance company or third party administrator) as it may deem necessary or desirable in connection with the administration of claims or other operations of the Plan. The Plan Administrator may also appoint a benefit committee consisting of not less than three (3) persons to assist the Plan Administrator either generally or specifically in reviewing claims for benefits, subject to the right of the Board of Trustees 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 Board of Trustees (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, Board of Trustees, or such delegate will be fully protected in respect to any action taken or permitted in good faith in reliance on such table, valuations, certificates, etc.

- E. **Fiduciary Liability.** To the extent permitted by law, neither the Plan Administrator nor any other person will incur any liability for any acts or for failure to act.
- F. **Indemnification and Exculpation.** The Plan Administrator and the members of any committee appointed by the Plan Administrator to assist in administering the Plan, its agents, and officers, directors, and Employees of the Trust Fund will be indemnified and held harmless by the Trust Fund 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 Trust Fund'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 Trustees, 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 Trust Fund.
- H. **Bonding.** Unless required by ERISA, by the Board of Trustees, 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 Trust Fund unless the Trust Fund 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.** The coverage of any Retiree and his or her Eligible Dependents shall automatically cease immediately upon the day indicated below:
 - (a) On the day the Retiree returns to work in a the jurisdiction of Local 877 for forty (40) or more hours in any calendar month
 - (b) On the day the Retiree and/or the Contributing Employer fail to make timely contributions for coverage to the Fund
 - (c) On the day that the Contributing Employer's CBA or participation agreement terminates

- 2. Earlier Termination of Eligible Dependent Coverage.** The coverage of any Eligible Dependent will terminate before the termination of the Retiree's coverage on the earlier of (i) the date that the dependent no longer satisfies the definition of an Eligible Dependent, (ii) for spouses, on the effective date of any divorce or legal separation (except for those who qualify as an Eligible Dependent as defined in the General Definitions section of this Plan, or (iii) the last day of the period in which the Retiree fails to make any required contribution for Eligible Dependent coverage.

- B. Certificate of Coverage.** As mandated by the Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA"), the Plan will provide a Certificate of Coverage to any Covered Person after the Employee loses coverage under the Plan. In addition, a Certificate will be provided upon request, if the request is made within twenty-four (24) months after the Covered Person loses coverage under the Plan. In that case, the Certificate will be provided at the earliest time that the Plan, acting in a reasonable and prompt fashion, can furnish the same.

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

1. The name of the Plan;
2. The date of the Certificate;
3. A statement that the Covered Person has at least twelve (12) months or in the case of a Late Enrollee, eighteen (18) months of Creditable Coverage, not counting days of coverage before a Significant Break in Coverage, or the date any Waiting Period (and affiliation period, if applicable) began;
4. The date Creditable Coverage began;
5. The Plan Administrator; and
6. Contact information for the Plan.

XI. HIPAA PRIVACY AND SECURITY PROVISIONS

There are three circumstances under which the Plan may disclose an individual's protected health information to the Board of Trustees of the Fund ("Plan Sponsor").

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

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

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

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

- The Plan Sponsor will only use or disclose an individual's protected health information for Plan administrative purposes, as required by law, or as permitted under the HIPAA regulations. See the Plan's privacy notice for more information about permitted uses and disclosures of protected health information under HIPAA.
- If the Plan Sponsor discloses any of an individual's protected health information to any of its agents or subcontractors, the Plan Sponsor will require the agent or subcontractor to keep an individual's protected health information as required by the HIPAA regulations.
- The Plan Sponsor will not use or disclose an individual's protected health information for employment related actions or decisions or in connection with any other benefit or benefit plan of the Plan Sponsor unless permitted under HIPAA.
- The Plan Sponsor will promptly report to the Plan any use or disclosure of an individual's protected health information that is inconsistent with the uses or disclosures allowed in this summary.
- The Plan Sponsor will allow an individual or the Plan to inspect and copy any protected health information about the individual that is in the Plan Sponsor's custody and control. The HIPAA Regulations set forth the rules that an individual and the Plan must follow in this regard. There are some exceptions.

- The Plan Sponsor will amend, or allow the Plan to amend, any portion of an individual's protected health information to the extent permitted or required under the HIPAA Regulations.
- With respect to some types of disclosures, the Plan Sponsor will keep a disclosure log. The disclosure log will go back for six years (but not before April 14, 2004). An individual has a right to see the disclosure log. The Plan Sponsor does not have to maintain the log if disclosures are for certain Plan related purposes, such as payment of benefits or health care operations.
- The Plan Sponsor will make its internal practices, books, and records, relating to its use and disclosure of an individual's protected health information available to the Plan and to the U.S. Department of Health and Human Services.
- The Plan Sponsor will, if feasible, return or destroy all of an individual's protected health information in the Plan Sponsor's custody or control that the Plan Sponsor has received from the Plan or from any business Employee when the Plan Sponsor no longer needs an individual's protected health information to administer the Plan. If it is not feasible for the Plan Sponsor to return or destroy an individual's protected health information, the Plan Sponsor will limit the use or disclosure of any protected health information that it cannot feasibly return or destroy to those purposes that make return or destruction of the information infeasible.

The following classes of Members 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:

- | |
|---|
| <ul style="list-style-type: none"> ▪ Trustees of the Plan ▪ Executive Director ▪ Members and other workforce members at the direction of the above listed classes of Members ▪ Administrative Assistant to the Executive Director |
|---|

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

Security Provisions

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

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

XII. SUBROGATION AND REIMBURSEMENT PROVISIONS

A. Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance payment of medical benefits in those situations where an injury, illness, disease or disability is caused in whole or in part by, or results from the acts or omissions of a Covered Person or a third party, where other insurance is available, including but not limited to no-fault, uninsured motorist, underinsured motorist, and medical payment provisions (collectively "Coverage").
2. Covered Person, his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain one hundred percent (100%) of the Plan's conditional payment of benefits or the full extent of payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. By accepting benefits the Covered Person agrees the Plan shall have an equitable lien on any funds received by the Covered Person and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person agrees to include the Plan's name as a co-payee on any and all settlement drafts.
3. In the event a Covered Person settles, recovers, or is reimbursed by any Coverage, the Covered Person agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person. If the Covered Person fails to reimburse the Plan out of any judgment or settlement received, the Covered Person will be responsible for any and all expenses (fees and costs) associated with the Plan's attempt to recover such money.

B. Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person agrees to subrogate the Plan to any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person is entitled, regardless of how classified or characterized.
2. If a Covered Person receives or becomes entitled to receive benefits, an automatic equitable subrogation lien attaches in favor of the Plan to any claim, which any Covered Person may have against any Coverage and/or party causing the illness or injury to the extent of such conditional payment by the Plan plus reasonable costs of collection.

3. The Plan may in its own name or in the name of the Covered Person commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional payments advanced by the Plan.
4. If the Covered Person fails to file a claim or pursue damages against:
 - a) The responsible party, its insurer, or any other source on behalf of that party;
 - b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c) Any policy of insurance from any insurance company or guarantor of a third party;
 - d) Worker's compensation or other liability insurance company; or,
 - e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage;

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

C. Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other similar legal theory, without regard to whether the Covered Person is fully compensated by his/her recovery from all sources. The Plan shall have an equitable lien which supersedes all common law or statutory rules, doctrines, and laws of any state prohibiting assignment of rights which interferes with or compromises in any way the Plan's equitable subrogation lien. The obligation exists regardless of how the judgment or settlement is classified and whether or not the judgment or settlement specifically designates the recovery or a portion of it as including medical, disability, or other expenses. If the Covered Person's recovery is less than the benefits paid, then the Plan is entitled to be paid all of the recovery achieved.
2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or expenses of litigation may be deducted from the Plan's recovery without the prior, expressed written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person, whether under

the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.

4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person.
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable illness injury, disease or disability.

D. Excess Insurance

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

- a) The responsible party, its insurer, or any other source on behalf of that party;
- b) Any first party insurance through medical payment coverage, personal injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
- c) Any policy of insurance from any insurance company or guarantor of a third party;
- d) Worker's compensation or other liability insurance company; or
- e) Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit payments, and school insurance coverage.

E. Separation of Funds

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

F. Wrongful Death

In the event that the Covered Person dies as a result of his or her injuries and a wrongful death or survivor claim is asserted against a third party or any Coverage, the Plan's subrogation and reimbursement rights shall still apply.

G. Obligations

1. It is the Covered Person's obligation at all times, both prior to and after payment of medical benefits by the Plan:
 - a) To cooperate with the Plan, or any representatives of the Plan, in protecting its rights, including discovery, attending depositions, and/or cooperating in trial to preserve the Plan's rights;
 - b) To provide the Plan with pertinent information regarding the illness, disease, disability, or injury, including accident reports, settlement information and any other requested additional information;
 - c) To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights;
 - d) To do nothing to prejudice the Plan's rights of subrogation and reimbursement
 - e) To promptly reimburse the Plan when a recovery through settlement, judgment, award or other payment is received; and
 - f) To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
2. If the Covered Person and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, as a result of said injury or condition, out of any proceeds, judgment or settlement received, the Covered Person will be responsible for any and all expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person.
3. The Plan's rights to reimbursement and/or subrogation are in no way dependent upon the Covered Person's cooperation or adherence to these terms.

H. Offset

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

I. Minor Status

1. In the event the Covered Person is a minor as that term is defined by applicable law, the minor's parents or court-appointed guardian shall cooperate in any and all actions by the Plan to seek and obtain requisite court approval to bind the minor and his or her estate insofar as these subrogation and reimbursement provisions are concerned.
2. If the minor's parents or court-appointed guardian fail to take such action, the Plan shall have no obligation to advance payment of medical benefits on behalf of

the minor. Any court costs or legal fees associated with obtaining such approval shall be paid by the minor's parents or court-appointed guardian.

J. Language Interpretation

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

K. Severability

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

XIII. AMENDMENT AND TERMINATION OF PLAN

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

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

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

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

- B. Termination of Plan. Regardless of any other provision of this Plan, the Employer reserves the right to terminate this Plan at any time without prior notice. Such termination will be evidenced by a written resolution of the Employer. The Plan Administrator will provide notice of the Plan's termination as soon as is administratively feasible, but no more than 210 days after the last day of the final Plan Year.
- C. Termination by Dissolution, Insolvency, Bankruptcy, Merger, etc. This Plan will automatically terminate if the Employer (1) is legally dissolved; (2) makes any general assignment for the benefit of its creditors; (3) files for liquidation under the Bankruptcy Code; (4) merges or consolidates with any other entity and it is not the surviving entity; (5) sells or transfers substantially all of its assets; or (6) goes out of business, unless the Employer's successor in interest agrees to assume the liabilities under this Plan as to the Covered Persons.

XIV. GENERAL PROVISIONS

- A. **Company Funding.** All benefits paid under this Plan shall be paid in cash from the general assets of the Employer. No Employees 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.

XV. CLAIMS AND APPEALS PROCEDURES AND STATEMENT OF RIGHTS

Claims and Appeals Procedures

This section describes a Covered Member's or Covered Retiree'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 makes initial claim and initial appeal determinations based on the specific terms of the Plan. The Plan Administrator has final authority to determine the amount of benefits that will be paid on any particular benefit claim, and has complete 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 Members' or Covered Retiree's rights are included in Sections A-F below.

1. All initial claims must be filed within one (1) year of the Expense Incurred Date (defined in Article III of this Plan Document).
2. As directed by the Plan Administrator, the Claim Administrator will make an initial determination about benefits payable based on the specific terms of the Plan and will notify the Covered Member or Covered Retiree 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 Member or Covered Retiree disputes the determination, he or she may contact the Claim Administrator to confirm that the claim was properly processed. The Covered Member or Covered Retiree may also immediately file a formal appeal (see *F. Appeals of Denied Claims*, below).
4. As directed by the Plan Administrator, the Claim Administrator will review any appeal filed, 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. Appeals of Denied Claims*, Chart B below).
5. If the first appeal is denied, the Covered Member or Covered Retiree may file a second appeal within the time periods specified in Chart B, below. The appeal will be reviewed by the Plan Administrator, who holds the authority to make the final determination about benefits payable under the Plan. The second appeal is the final appeal available under the Plan.

A. Who May File a Claim

A claim may be filed by a Covered Member or Covered Retiree, his or her authorized representative, or his or her health care service provider. To designate an “authorized representative,” a Covered Member 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 Member 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 Member or Covered Retiree to whom the claim relates or, as applicable, to the Covered Member’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 Member or Covered Retiree or the ability of the Covered Member or Covered Retiree to regain maximum function, or (b) in the opinion of a physician with knowledge of the Covered Member’s or Covered Retiree’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 Member or Covered Retiree 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 Member or Covered Retiree 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 (800) 532-7575 or by any method available for non-urgent and post-service claims.
2. *Non-urgent care claims* and *post-service claims* must be filed using a written form available from the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:
 - U.S. Mail
 - Hand delivery
 - Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	<u>Mailing Address:</u> 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 CLAIMS	15 days	15 days	15 days	45 days maximum
POST-SERVICE CLAIMS	30 days	15 days	30 days	45 days maximum

*A determination will be made within 48 hours of receiving both a properly filed claim and any missing information.

**If the claim is received at least 24 hours before the end of the previously approved course of treatment. Otherwise the time limits are the same as for Urgent Care Claims.

E. How Claims are Paid

If a claim is approved, in whole or in part, and a Covered Member or Covered Retiree 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 Member or Covered Retiree. Third parties who have purchased or been assigned benefits by physicians or other providers will *not* be reimbursed directly by the Plan.

F. Appeals of Denied Claims

If a claim is denied in whole or in part, a claimant may file an appeal of the adverse benefit determination. Before filing an appeal, a claimant may first want to contact the Claim Administrator at (800) 532-7575 to verify that the claim was correctly processed under the terms of the Plan, but is not required to do so.

Initial appeals must be filed within 180 days of the initial claim denial; second appeals must be filed within 60 days of the initial appeal denial. Any appeal received after these deadlines will be denied. Chart B below shows details of the deadlines for filing appeals and making determinations upon review.

How an initial or second appeal may be filed depends on the type of appeal:

1. *Urgent care appeals* may be submitted verbally by calling the Claim Administrator at (800) 532-7575 or by any method available for non-urgent and post-service appeals.
2. *Non-urgent care appeals* and *post-service appeals* must be in writing and must be submitted to the Claim Administrator, and must be submitted to the Claim Administrator using one of the following methods:
 - U.S. Mail
 - Hand delivery
 - Facsimile (FAX): (508) 329-4812

Health Plans, Inc. 1500 West Park Drive, Suite 330 Westborough, MA 01581	<u>Mailing Address:</u> Health Plans, Inc. P.O. Box 5199 Westborough, MA 01581
--	--

Written appeals *must* include the following information:

- (a) The patient's name.
- (b) The patient's Plan identification number.
- (c) Sufficient information to identify the claim or claims being appealed, such as the date of service, provider name, procedure (if known) and claim number (if available).
- (d) A statement that the Covered Member or Covered Retiree (or authorized representative on behalf of the Covered Member or Covered Retiree) is filing an appeal.

In making an appeal, the Covered Member or Covered Retiree also may:

- Review pertinent documents and submit issues and comments in writing.
- Designate an authorized representative to act on the Covered Members or Covered Retiree's behalf for the purposes of the appeal.
- Submit written comments, documents, records, or any other matter relevant to his or her appeal, 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, upon request and free of charge.

All appeals will be given a review that takes into account all comments, documents, records, and other information submitted by the claimant relating to the appeal, 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 will be reviewed by a health care professional retained by the Plan who did not participate in the initial denial.

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

CHART B – Time Limits Regarding Initial and Second Appeals				
Type of Claim	Maximum period for Claimant to file initial appeal after initial denial	Maximum period for issuing determination regarding initial appeal	Maximum period for Claimant to file second appeal following denial of initial appeal in whole or in part	Maximum period for issuing determination regarding second appeal
URGENT CARE CLAIMS (including urgent concurrent care claims)	180 days	72 hours	60 days	72 hours
PRE-SERVICE AND NON-URGENT CONCURRENT CLAIMS	180 days	15 days	60 days	15 days
POST-SERVICE CLAIMS	180 days	30 days	60 days	30 days

If the second appeal is denied in whole or in part, the Covered Member or Covered Retiree has the right to bring a civil action against the Plan under Section 502(a) of the Employee Retirement Income Security Act (ERISA).

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 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) and updated Summary Plan Description. The Plan Administrator may make a reasonable charge for the copies;
- (3) Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report;
- (4) Continue health care coverage for himself or herself, spouse, or dependents if there is a loss of coverage under the Plan as a result of a COBRA Qualifying Event. The individual or his or her dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing his or her COBRA continuation coverage rights; and
- (5) Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under the Plan, if the individual has Creditable Coverage from another plan. The individual should be provided a certificate of Creditable Coverage, free of charge, from the Plan when the individual loses coverage under the Plan, when the individual becomes entitled to elect COBRA continuation coverage, when his or her COBRA continuation coverage ceases, if the individual requests it before losing coverage, or if the individual requests it up to 24 months after losing coverage. Without evidence of Creditable Coverage, the individual may be subject to a pre-existing condition exclusion for 12 months (18 months for Late Enrollees) after the individual's enrollment date in his or her coverage under the Plan.

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

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

If the individual has a claim for benefits that is denied or ignored, in whole or in part, the individual may file suit in a state or federal court after exhausting the appeals and external review process described in this Article. In addition, if the individual disagrees with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, the individual may file suit in federal court. If it should happen that the Plan's fiduciaries misuse the Plan's money, or if the individual is discriminated against for asserting his or her rights, the individual may seek assistance from the U.S. Department of Labor, or the individual may file suit in a federal court. The court will decide who should pay court costs and legal fees. If the individual is successful the court may order the person the individual has sued to pay these costs and fees. If the individual loses, the court may order the individual to pay these costs and fees, for example, if it finds his or her claim is frivolous.

If the individual has any questions about this Plan, the individual should contact the Claim 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.

Version 11.2