



Medicare Complementary Plan Summary Plan Description and Plan Document

Effective: January 1, 1988
Revised: September 1, 2022

Administered by:



UNIVERSITY SYSTEM OF NEW HAMPSHIRE MEDICARE COMPLEMENTARY PLAN

INTRODUCTION

This document is a summary of the University System of New Hampshire Medicare Complementary Plan (the "Plan").

This document is provided to help you understand how the Plan works. It highlights what types of Expenses are covered under the Plan, definitions you need to know, how to file claims and what your legal rights are under the Plan. It is important that you read this document carefully so you are aware of the benefits available and your responsibilities under this Plan. Failure to follow the requirements of this Plan may result in a delay of coverage or no coverage at all. Coverage under the Plan can be reduced or denied because of certain provisions of the Plan, such as coordination of benefits, subrogation, exclusions, pre-certification and prior authorization requirements, and lack of medical necessity. These requirements are summarized in this document. If you have any questions, you should contact the Plan Administrator or the Contract Administrator.

Each Covered Person is entitled to the benefits under the Plan, as outlined in this Plan Document. To obtain benefits from the Plan, the Covered Person must ultimately submit a diagnostic bill to the Contract Administrator, Employee Benefit Plan Administration, LLC dba Employee Benefit Plan Administration (EBPA) for processing. This claim submission is required for reimbursement to the Retiree or direct Payment to the service Provider by the University System of New Hampshire Medicare Complementary Plan. The provider will submit a diagnostic bill directly to the Contract Administrator on the Covered Person's behalf. The Plan will pay benefits secondary to Medicare.

In any event where a question may arise as to a Claim for Benefits or denial of a Claim for Benefits, the Employer, the Contract Administrator (also known as the third-party administrator) and any other persons that may be associated with the Plan's operation will be guided solely by this Plan Document, which is also the Summary Plan Description. A clerical error will neither invalidate the Employee's coverage if otherwise validly in force nor continue coverage otherwise validly terminated.

As explained in this document, the Plan Sponsor expressly reserves the right to amend or terminate the Plan or any provision of the Plan at any time and for any reason or no reason at all in its sole discretion. The Plan Sponsor may reflect Plan amendments in a separate document called a "summary of material modifications" or "SMM". SMMs supplement, replace, and supersede any conflicting information contained in this Plan Document. You should read all SMMs you receive.

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GENERAL INFORMATION

Name of the Plan: University System of New Hampshire Medicare Complementary Plan

Plan Sponsor/Plan Administrator: University System of New Hampshire
5 Chenell Drive, Suite 301
Concord, NH 03301
(603) 862-1800

Plan Number: 501

Contract Administrator Group Number: 10200

Plan(s) Covered: The Plan is a welfare Plan providing medical and prescription drug coverage.

Plan Sponsor's Federal Tax Identification Number: 02-6000937

Plan Effective Date: January 1, 1988

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Plan Revision Date: September 1, 2022 – This document replaces the previous Employee Benefit Plan Summary Plan Description and Plan Document in its entirety. All claims incurred prior to September 1, 2022 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator/Pre-Certification Administrator:

Employee Benefit Plan Administration, LLC dba Employee Benefit Plan
Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
Customer Service: (603) 778-7106 or (800) 578-3272 (EBPA)
Pre-Certification: (800) 204-5990

Agency for Service of Legal Process: University System of New Hampshire
5 Chenell Drive, Suite 301
Concord, NH 03301

Service of process may also be made upon the Plan Administrator.

Contributions: The Plan provides Contributory Coverage, meaning that Employees must contribute towards the cost of coverage under the Plan. The Plan Sponsor will determine the amount of contributions that Employees will be required to pay for coverage each year, in its sole discretion but subject to applicable law. The Plan Sponsor will be responsible for any amounts in excess of the contributions required by Employees. Operating Expenses may be paid out of Plan Sponsor and/or Employee contributions.

GENERAL INFORMATION

Name of the Plan: University System of New Hampshire Medicare Complementary Plan

Plan Sponsor/Plan Administrator: University System of New Hampshire
Dunlap Center
25 Concord Road
Durham, NH 03824-3545
(603) 862-1800

Plan Number: 501

Contract Administrator Group Number: 10200

Plan(s) Covered: The Plan is a welfare Plan providing medical and prescription drug coverage.

Plan Sponsor's Federal Tax Identification Number: 02-6000937

Plan Effective Date: January 1, 1988

Plan Anniversary Date: January 1st

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Employee Benefit Plan Administration, LLC dba Employee Benefit Plan
Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
Customer Service: (603) 778-7106 or (800) 578-3272 (EBPA)
Pre-Certification: (800) 204-5990

Agency for Service of Legal Process: University System of New Hampshire
Dunlap Center
25 Concord Road
Durham, NH

Service of process may also be made upon the Plan Administrator.

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Eligibility Requirements: Retired faculty or staff members age sixty-five (65) or over who elected to retain Retiree medical coverage at age sixty-five (65); their spouses, their disabled Dependents age sixty-five (65) or over and others as determined by the Employer at the time of initial enrollment into the Plan. Contact the University System of New Hampshire Benefits Office for information on eligibility and for more information regarding this Plan.

IMPORTANT NOTE: The benefits of the Medicare Complementary Plan will automatically be adjusted to accommodate changes in Medicare benefits.

Effective Date of Coverage: The first day of the month that the Retiree turns age sixty-five (65) or becomes Medicare eligible.

Termination Date: See "Termination of Benefits" section.

What is a Medicare Complementary Plan?

A Medicare Complementary Plan is coverage which supplements Medicare approved benefits and also provides limited Major Medical benefits.

Part A of Medicare helps pay for inpatient Hospital or Skilled Nursing Facility care and related inpatient Expenses, home health care and Hospice care. Part B helps pay for doctor's services, outpatient Hospital services, durable medical equipment and other services and supplies not covered under Part A. Medicare Deductible and Copayment amounts and eligible benefits vary each year, so refer to a current Medicare Handbook for further information and requirements.

When Should I enroll in Medicare?

Medicare becomes available at the beginning of the month in which you turn sixty-five (65) whether you are retired or still working. You automatically apply for Medicare when you apply for Social Security benefits. If you plan to work past age sixty-five (65), you should apply for Medicare Part A when you turn sixty-five (65). You should apply for Medicare Part B when you actually retire. You must be enrolled in both Medicare Parts A and B to be eligible for full coverage under this Medicare Complementary Plan. If you are eligible for Medicare Parts A and B, but have not enrolled, benefits will be payable at the same level as if you were receiving full Medicare benefits.

Eligibility Requirements: Retired faculty or staff members age sixty-five (65) or over who elected to retain Retiree medical coverage at age sixty-five (65); their spouses, Same-Sex Domestic Partners (through December 31, 2009 or Domestic Partners with USNH approved hardship thereafter), Civil Union Partners, their disabled Dependents age sixty-five (65) or over and others as determined by the Employer at the time of initial enrollment into the Plan. Contact the University System of New Hampshire Benefits Office for information on eligibility and for more information regarding this Plan.

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**UNIVERSITY SYSTEM OF NEW HAMPSHIRE
MEDICAL SCHEDULE OF BENEFITS
RETIREE MEDICARE COMPLEMENT**

INPATIENT HOSPITAL BENEFITS	MEDICARE PART "A" PAYS	YOUR MEDICARE COMPLEMENTARY PLAN PAYS	YOU PAY
First 60 days of Medicare benefit period	100% of covered Expenses except initial inpatient Deductible	Part A inpatient Deductible	\$0
Next 30 days (61st to 90th day)	100% of covered Expenses except current Copayment amount per day	Balance per day not paid by Medicare	\$0
Next 60 days are one-time lifetime reserve days (91st to 150th day)	100% of covered Expenses except current Copayment amount per day	Balance per day not paid by Medicare	\$0
After 150 days	\$0	80% of covered Expenses	20% of covered Expenses

Note: Inpatient psychiatric care is limited to 190 days per lifetime.

SKILLED NURSING FACILITY BENEFITS	MEDICARE PAYS	YOUR MEDICARE COMPLEMENTARY PLAN PAYS	YOU PAY
First 20 days	100% of covered Expenses	\$0	\$0
Next 80 days (21st to 100th day)	100% of covered Expenses except current Copayment amount per day	Balance per day not paid by Medicare	\$0
After 100 days	\$0	Refer to the Major Medical Benefits portion of your Plan	Refer to the Major Medical Benefits portion of your Plan

	MEDICARE PAYS	YOUR MEDICARE COMPLEMENTARY PLAN PAYS	YOU PAY
HOME HEALTH CARE (Refer to home health care benefits in this Summary Plan Description.)	100% of most covered Expenses, except durable medical equipment (80% Copayment)	\$0 for most covered Expenses, 20% Copayment for durable medical equipment	\$0
HOSPICE CARE (Refer to Hospice care benefits in this Summary Plan Description.)	100% of most covered Expenses, except inpatient respite care (5% Copayment of Medicare allowed rate) and outpatient drugs (limited Copayment may be required) and including counseling	\$0 for most covered Expenses, 95% Copayment of Medicare allowed rate) for inpatient respite care	\$0

MEDICAL SERVICE BENEFITS	MEDICARE PART "B" PAYS	YOUR MEDICARE COMPLEMENTARY PLAN PAYS	YOU PAY
Physician/special practitioner services, Hospital outpatient care, prosthetic devices, durable medical equipment, ambulance	80% of covered Expenses after calendar year Deductible	Part B Deductible and 20% of covered Expenses	Any charges not allowed by Medicare or this Plan
OTHER COVERED EXPENSES Medical, surgical, diagnostic, and therapy services, Mental Illness Treatment (limited Payment for non-hospital), blood transfusions (after 3 units), drugs which cannot be self-administered, second surgical opinions, limited pap smears/mammograms, organ transplants, dialysis.	80% of covered Expenses after calendar year Deductible	Part B Deductible and 20% of covered Expenses	Any charges not allowed by Medicare or this Plan

NOTES: The Retiree should check to see if the facility qualifies for Medicare. Skilled Nursing Facility confinement must follow confinement in a Hospital of at least three (3) consecutive days. **Most** routine Expenses are **not** covered by Medicare. **Medicare Complementary Benefits will automatically be adjusted to accommodate changes in Medicare benefits.**

MAJOR MEDICAL EXPENSE BENEFITS

Further Expenses not covered by Medicare or our Medicare Complementary Benefits will be eligible for major medical Expense benefits. Refer to your Plan Document or Summary Plan Description for more complete information.

Maximum Major Medical Lifetime Benefit - \$10,000

Maximum Prescription Lifetime Benefit - \$30,000

Calendar Year Deductible - \$100 per individual for Major Medical

Copayment - The Plan pays 80% of Reasonable and Customary charges

Maximum Major Medical and Prescription Lifetime Benefit Limit - \$40,000

If a Retiree does not use the maximum for prescriptions and they incur major medical Expenses that are beyond the \$10,000, with USNH approval, they may be reimbursed for those Expenses as long as the maximum reimbursement for prescriptions and major medical Expenses do not exceed \$40,000.

A Retiree may also use \$5,000 of the Maximum Major Medical Lifetime Benefit, with USNH approval, toward the maximum prescription lifetime benefit as long as the maximum reimbursement for prescriptions and major medical Expenses do not exceed \$40,000. However, a Retiree will only be able to use this transfer as a one-time increment of up to \$5,000. They may not transfer more than \$5,000.

MAJOR MEDICAL BENEFITS

After you meet the \$100 per individual major medical calendar year Deductible, your Medicare Complementary Plan will provide benefits for Hospital admissions for which Medicare benefits have been exhausted and certain benefits or excess amounts not covered under Part B of Medicare, provided benefits are non-assigned (you are being billed for the balance).

Treatment of Mental Illness, alcoholism, and drug addiction are also covered under this portion of your Plan, as well as benefits available under major medical benefits which are not paid by Medicare or any other portion of your Medicare Complementary Plan. Refer to this Summary Plan Description (SPD) for further description of covered Expenses under the major medical portion of this Plan.

Major medical benefits are also provided for foreign short-term general Hospitals and for Physician's services provided outside the United States which do not qualify for benefits under Medicare.

Maximum Major Medical Lifetime Benefit: The lifetime maximum for all eligible benefits under the major medical portion of the Plan is \$10,000 per Covered Person. A Retiree may use \$5,000 of the Maximum Major Medical Lifetime Benefit, with USNH approval, toward the maximum prescription lifetime benefit as long as the maximum reimbursement for prescriptions and major medical Expenses do not exceed \$40,000. However, a Retiree will only be able to use this transfer as a one-time increment of up to \$5,000. They may not transfer more than \$5,000.

Maximum Prescription Lifetime Benefit: The lifetime maximum for all eligible benefits under the prescription portion of the Plan is \$30,000 per Covered Person. If a Retiree does not use the maximum for prescriptions and they incur major medical Expenses that are beyond the \$10,000, with USNH approval, they may be reimbursed for those Expenses as long as the maximum reimbursement for prescriptions and major medical Expenses do not exceed \$40,000.

Copayment Provision: The Plan will pay 80% of Reasonable and Customary charges each calendar year for Expenses incurred during that calendar year.

Maximum Major Medical and Prescription Lifetime Benefit: \$40,000

Medical Deductible Carry-Over Provision: If, after September 30th of any year, a Covered Person incurs services for which any or all of the medical Deductible amount must be paid, then that portion of the medical Deductible paid by the Covered Person after September 30th will be deemed to have been paid toward the next year's medical Deductible as well.

COVERED MAJOR MEDICAL EXPENSES

(Charges which are approved by the Plan and not paid under any other portion of this Plan or by Medicare)

Including but not limited to:

- Medical and surgical services, including anesthesia
- Hospital charges for room and board and general nursing care
- Emergency care following an accident and other outpatient Hospital charges
- Surgery and related Expenses, including Ambulatory Surgical Centers
- Convalescent/Extended Care/Rehabilitative Care Facility
- Artificial limbs or eyes, casts, orthotics, prosthetics, etc.
- Durable medical equipment
- Diagnostic x-ray and lab services
- Local professional ambulance service
- Private duty nursing care
- Mental Illness, alcoholism, and drug addiction Treatment
- Services of your doctor or approved practitioner
- Drugs and biologicals, including insulin and syringes
- Transfusions of blood and blood components (unreplaced)
- Physical/occupational therapy and speech pathology services
- All commercially available vaccines (like the shingles vaccine) when Medically Necessary to prevent Illness, except for vaccines that are covered under Medicare Part B

INPATIENT HOSPITAL BENEFITS

To Complement Medicare Part A

The combined Medicare Part A and Medicare Complementary Plan covers semi-private room (two (2) or more beds per room) and many other related medical services, if deemed necessary by your Physician.

During the first sixty (60) days in the Hospital, your Medicare Complementary Plan pays the current Medicare Part A Deductible, which begins a benefit period. Medicare then covers the full semi-private services for a sixty (60) day period.

For the second part of a benefit period – the 61st through the 90th day in the Hospital – your Medicare Complementary Plan pays the balance (the Copayment) of the Medicare room and board allowance and Medicare covers the remainder of approved services. Consult your Medicare Handbook for a description of these benefits.

Should your Hospital stay extend beyond the first ninety (90) days of this benefit period, you will begin to use your sixty (60) lifetime reserve days. Your Medicare Complementary Plan will pay the balance after Medicare pays its portion of the claim, in the same way as prior benefit days. However, each lifetime reserve day that is used cannot be reused for any future Hospital admission. If you do not wish to apply your reserve days to a Hospital stay, you must tell the Hospital in writing.

Note: A new benefit period begins sixty (60) days after discharge from any facility primarily engaged in providing skilled nursing care; i.e. Hospital, Skilled Nursing Facility or nursing home.

Utilization Review Committee

Each approved Hospital, as required by Medicare, has a Utilization Review Committee. This Committee of medical experts, along with your doctor and the Hospital's patient care coordinator, determine how much Hospital care you need for the appropriate Treatment of your condition. The review process helps avoid medically unnecessary health care costs. **If you disagree with a decision on the amount Medicare will pay on a claim or whether your medical care is covered by Medicare, you have the right to appeal the decision.**

COVERED INPATIENT HOSPITAL SERVICES

Including but not limited to:

- A semi-private room (two to four beds in a room)
- All your meals, including special diets
- Regular nursing services
- Operating and recovery rooms, special care units, such as intensive care or coronary care units
- Drugs furnished by the facility during your stay
- Blood transfusions (after 3 unit Deductible) furnished during your stay
- Hospital charges for dental Treatment requiring a Hospital stay
- Use of appliances such as a wheelchair furnished by the facility
- Lab tests billed by the Hospital
- X-rays and other radiology services, including radiation therapy, billed by the Hospital
- Medical supplies, such as casts, surgical dressings and splints furnished by the facility
- Rehabilitation services, such as physical or occupational therapy and speech pathology services

PHYSICIAN'S SERVICES/HOSPITAL OUTPATIENT BENEFITS

To Complement Medicare Part B

Your Plan will help you meet the required Medicare Part B Deductible by paying the covered inpatient Physician's charges, as well as the services listed below. Once the Deductible is met, Medicare pays 80% and the Medicare Complementary Plan pays 20% of covered services. Benefits toward covered services are based on the amount **approved** by Medicare, not necessarily the billed amount shown on the claim form. However, any disallowed amount may be covered under the major medical benefits portion of this Plan.

COVERED PHYSICIAN'S SERVICES

Including but not limited to:

- Medical and surgical services, including anesthesia
- Diagnostic tests and procedures that are part of your Treatment
- Emergency care following an accident
- Radiology and pathology services provided by doctors while you are a Hospital inpatient or outpatient
- Diagnostic x-rays
- Electrocardiograms and electroencephalograms
- Mental Illness Treatment/partial hospitalization (non-hospital care has a limited Copayment)
- Services of your doctor's office nurse
- Drugs and biologicals that cannot be self-administered
- Transfusions of blood and blood components (3 unit Deductible)
- Physical or occupational therapy and speech pathology services
- Second surgical opinions and any other charges which are approved by Medicare

COVERED OUTPATIENT HOSPITAL SERVICES

Including but not limited to:

- Services in an emergency room or outpatient clinic, including same-day surgery
- Drugs and biologicals that cannot be self-administered
- Lab tests billed by the Hospital
- Blood transfusions furnished to you as an outpatient
- Mental health care in a partial hospitalization psychiatric program, if a Physician certifies that inpatient care would otherwise be required
- X-rays and other radiology services, including radiation therapy, billed by the Hospital
- Medical supplies, such as casts, surgical dressings, and splints
- Ambulance services

NOTE: Most routine Expenses (not Medically Necessary) are not covered, except as specified in the Medicare Handbook. Eligible services must be provided by a Medicare approved Physician or special practitioner.

SKILLED NURSING FACILITY BENEFITS

After making a determination regarding your level of care, Medicare may approve coverage for inpatient care in a Medicare participating Skilled Nursing Facility i.e. nursing home, Extended Care Facility, provided you were admitted within thirty (30) days of a Hospital Confinement of at least three (3) days. If approved for Medicare Payment, Medicare will pay the first twenty (20) days in each benefit period in full. Then Medicare will pay for all covered services, except for the current disallowed amount per day, for the 21st through the 100th day. Your Medicare Complementary Plan will pay the disallowed amount (the balance) per day for the 21st through the 100th day, thus providing you with 100% coverage.

COVERED SKILLED NURSING FACILITY SERVICES

Including but not limited to:

- A semi-private room (two to four beds in a room)
- All your meals, including special diets
- Regular nursing services
- Physical, occupational and speech therapy
- Drugs furnished by the facility during your stay
- Blood transfusions furnished during your stay
- Medical supplies such as splints and casts furnished by the facility
- Use of appliances such as a wheelchair furnished by the facility

NOTE: Medicare will not pay for Skilled Nursing/Rehabilitative Care unless the care is non-Custodial Care, a medical professional certifies that Skilled Nursing/Rehabilitative Care is required on a daily basis, and the Medicare intermediary approves of the stay.

HOME HEALTH CARE BENEFITS

Medicare covers Medically Necessary skilled nursing and other therapeutic services provided by an approved Home Health Care Agency in your home. In order to qualify for benefits, you must be confined to your home and under the care of a Physician who provides a Home Health Care Plan for you. The care must include intermittent skilled nursing care (up to twenty-one (21) consecutive days at eight (8) hours per day), physical, or speech therapy, and occupational therapy after it is determined you no longer need the required care. In addition to these services, home health aides, medical social services, and medical supplies may be covered. Medicare will pay 80% of Expenses for durable medical equipment and your Medicare Complementary Plan will pay the 20% balance, providing 100% coverage for home health care services.

NOTE: Medicare will not cover twenty-four (24) hour a day home nursing care, drugs and biologicals, meals delivered to your home, homemaker services, or blood transfusions.

HOSPICE CARE BENEFITS

Hospice care provides medical and social support services to terminally ill individuals, both in the home or in an approved facility. Hospice care includes some services not usually covered by Medicare, such as custodial services, homemaker services, and counseling. Medicare Part A pays for two ninety (90) day periods, followed by a thirty (30) day period and, when necessary, an extension period. Except for small Copayments for outpatient drugs and inpatient respite care (five (5) day maximum per stay), you will not pay for any Part A or B Medicare allowed Hospice care services. Read your Medicare Handbook carefully for further instructions on how to utilize your Hospice care benefits. Eligible services provided by an approved Hospice agency include:

COVERED HOSPICE AGENCY SERVICES

Including but not limited to:

- Nursing services
- Doctor's services
- Drugs, including outpatient drugs for pain relief and symptom management
- Physical therapy, occupational therapy, and speech-language pathology
- Home health aide and homemaker services
- Medical social services
- Medical supplies and appliances
- Short-term inpatient care, including respite care
- Counseling

NOTE: Part A of Medicare will not pay for Treatments other than pain relief and symptom management of the terminal illness. Regular Medicare may pay for other Treatments not directly related to the terminal illness.

GENERAL MEDICAL EXCLUSIONS AND LIMITATIONS

Expenses incurred for the following items will be considered excluded or limited, as explained in this section. The Plan Administrator will resolve, in its sole discretion, any question that arises as to whether an item is excluded or limited under the Plan.

1. Confinement, Treatment, services, or supplies except to the extent herein provided which are:
 - a) not furnished or ordered by a recognized provider and not Medically Necessary to diagnose or treat an Illness or Injury;
 - b) Experimental or Investigational in nature.
2. Services for disease or Injury sustained as a result of war, declared or undeclared. For all purposes of this Plan, terrorism is considered an act of war.
3. Services for any Injury or Illness which is incurred while taking part or attempting to take part in a riot or civil disobedience, or an illegal activity, including but not limited to misdemeanors and felonies, even if the cause of the Illness or Injury is not related to the commission of the illegal act. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an illegal act. This exclusion does not apply if the Injury or Illness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions, and conditions not diagnosed before the Injury or Illness).
4. Services involving a Covered Person who has taken part in any activity made illegal either due to the use of alcohol or a state of intoxication, even if the cause of the Illness or Injury is not related to the use of alcohol. It is not necessary that an arrest occur, criminal charges be filed, or, if filed, that a conviction result. Proof beyond a reasonable doubt is not required to be deemed an activity made illegal due to the use of alcohol or a state of intoxication. Expenses will be covered for injured Covered Persons other than the person partaking in an activity made illegal due to the use of alcohol or a state of intoxication, and Expenses may be covered for Substance Abuse Treatment as specified in this Plan, if applicable. This exclusion does not apply if the Injury or Illness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions, and conditions not diagnosed before the Injury or Illness).
5. Any accidental bodily Injury or Illness arising out of or in the course of any employment, regardless of whether the employment is for profit or compensation. This exclusion applies to all covered individuals, including but not limited to, self-employed individuals who choose not to provide themselves with insurance coverages, including, but not limited to, workers' compensation and occupational disease insurance, regardless of whether such coverage or coverages are required by law.
6. Dental Services, except to the extent herein expressly treated as a covered Expense in this Plan Document.
7. Vision therapy or orthoptics, except following surgery to the muscles controlling the eye or in Treatment of strabismus.

8. Eye refractions and any corrective Treatment or surgery to correct a refractive error (i.e. such as hyperopia, myopia, astigmatism, or radial keratotomy, etc.) or eye examinations for the purpose of prescribing corrective lenses or fitting or actual cost of corrective lenses except to the extent expressly treated as a covered Expense in this Plan Document (i.e. intra-ocular implant of lenses in the Treatment of cataracts).
9. Fitting or actual cost of hearing aids.
10. Treatment, services, supplies, and facilities provided by or in a Hospital owned or operated by any government or agency thereof where such care is provided at government Expense under a Plan or program established pursuant to the laws or regulations of any government or under a Plan or program under which any government participates other than as an Employer. The term "any government" includes the federal, veteran, state, provincial, municipal, local government, or any political subdivision thereof, of the United States or any other country. The Plan will not exclude benefits for a Covered Person who receives billable medical care at any of the above facilities.
11. Treatment, services, or supplies provided by the Retiree, spouse, parent, son, daughter, brother, or sister of a Covered Person or by a member of the Covered Person's household.
12. Treatment, services, or supplies for which there is no legal obligation to pay or for which no charges would be made if the person had no medical or dental coverage.
13. Services for which the Covered Person recovers the cost by legal action or settlement.
14. Services not directly related to the diagnosis or Treatment of an Illness or Injury (see chart for any exceptions).
15. Sex change operations and related charges before and after the surgery which are for the purpose of changing a person's sex.
16. Cosmetic or reconstructive surgery except for Medically Necessary Expenses:
 - a) to repair or alleviate the damage from an accident; or
 - b) incurred for reconstructive surgery following a mastectomy or for surgery and reconstruction of the other breast to produce symmetrical appearance; or
 - c) incurred as a result of a birth defect.
17. Custodial Care.
18. Routine foot care by a podiatrist (preventive maintenance and care), except as provided by Medicare.
19. Telephone, radio, television, and beautification services or for the preparation of reports, evaluations, and forms, or for missed appointments or for time spent traveling or in connection therewith that may be incurred by the Physician or Dentist or other Health Care Professional in the course of rendering services.
20. Routine or elective Expenses except to the extent expressly treated as a covered Expense in this Plan Document. This exclusion includes but is not limited to shoe inserts, ankle pads, printed material, arch supports, elastic stockings, fluoride, over-the-counter vitamins,

birth control pills or devices, nutritional or dietary counseling, food supplements, and any "over-the-counter drug" which can be purchased with or without a prescription or when no Injury or Illness is involved.

21. Treatment, services, or supplies incurred prior to the Covered Person's Effective Date of Coverage under this Plan or following the termination date of coverage under this Plan.
22. A portion of a charge for Treatment, services, or supplies in excess of the Reasonable and Customary Charges in the locality where it is rendered or in excess of the lifetime maximum benefit stated herein.
23. Chiropractic care, except Medicare approved manipulation of the spine.
24. Routine physical examinations and related charges required for employment or insurance.
25. Treatment on or to the teeth or gums, including oral surgery, except as provided herein.
26. Services resulting from an attempt by a Covered Person to commit a felony or while engaged in an unlawful occupation.
27. Marital counseling.
28. Temporomandibular joint dysfunction (TMJ) care, except as provided under major medical benefits.
29. Services performed by an individual who is not a Physician as defined under this Plan or by an institution which does not meet this Plan's definition of Hospital, Mental Hospital or Substance Abuse Treatment Facility.
30. Any home health care Expense for transportation.
31. Equipment which has no personal use in the absence of the condition for which it is prescribed including, but not limited to, air conditioners, air purifiers, dehumidifiers, waterbeds, and exercise equipment.
32. Services, supplies, care, and/or Treatment of an Injury or Illness that results from engaging in hazardous pursuit, hobby, or activity. A pursuit, hobby or activity is hazardous if it involves or exposes an individual to risk of a degree or nature not customarily undertaken in the course of the Covered Person's customary occupation or if it involves leisure time activities commonly considered as involving unusual or exceptional risks, characterized by a constant threat of danger or risk of bodily harm, including but not limited to: hang gliding, skydiving, bungee jumping, parasailing, use of all-terrain vehicles, rock climbing, use of explosives, automobile, motorcycle, aircraft, or speed boat racing, reckless operation of a vehicles or other machinery, and travel to countries with advisory warnings. This exclusion does not apply if the Injury or Illness (a) resulted from being the victim of an act of domestic violence, or (b) resulted from a documented medical condition (including both physical and mental health conditions, and conditions not diagnosed before the Injury or Illness).

33. Major medical claims submitted more than twelve (12) months after the Expense is incurred.
34. Treatment, services, or supplies incurred after the calendar year or lifetime maximum benefit has been exhausted.
35. The sale, use or administration of any Treatment, services, or supplies, which is in violation of the law, regardless of whether it would otherwise be an eligible expense under the Plan.

HOW TO CLAIM YOUR BENEFITS

For Hospital and Physician's Charges:

1. When the Covered Person visits the Hospital or Physician's office, they must show their Medicare Health Insurance Card and their EBPA Medicare Complementary Plan Card to the Hospital admittance clerk or the Physician's secretary.
2. The Hospital benefit provider (Part A) will provide a Hospital Form; the Physician benefit provider (Part B) will provide an Explanation of Medicare Benefits (EOMB).
3. If the provider has not already done so, send the Hospital Form or EOMB Form to Medicare. Medicare will send the Covered Person their Hospital or EOMB Form showing:
For Hospital Charges (Part A)
 - The amount allowed by Medicare;
 - The amount of the inpatient Deductible; and/or
 - The number of days and total amount paid by Medicare.
For Physician/Outpatient Hospital Charges (Part B)
 - The amount allowed by Medicare;
 - The amount applied to your Deductible; and/or
 - The total amount paid by Medicare.
4. Send the appropriate form or a copy to the Contract Administrator at the following address and they will make the supplementary benefit Payment:

Employee Benefit Plan Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
(603) 778-7106
(800) 578-EBPA (3272)

[Should the Retiree have any questions, please feel free to call or write to the Contract Administrator.]

MISCELLANEOUS PROVISIONS

Discharge: All Plan benefits made in accordance with the terms and provisions contained herein will discharge the Plan Sponsor from all future liability to the extent of the Payments so made.

Discretionary Authority: The Plan Administrator has the authority to interpret the Plan and to determine all questions that arise under it. This will include, but is not limited to: satisfaction of eligibility requirements, determination of medical necessity, and interpretation of terms contained in this document. The Plan Administrator's decisions will be binding on all Retirees, Dependents, and beneficiaries.

Except for functions reserved by the Plan to the Employer or Board of Directors, the Plan Administrator will control and manage the operation and administration of the Plan. The Plan Administrator will designate one or more named fiduciaries under the Plan, each with complete authority to review all denied claims for benefits under the Plan with respect to which it has been designated named Fiduciary (including, but not limited to, the denial of certification of medical necessity of Hospital or medical Treatment). In exercising its Fiduciary responsibilities, the named Fiduciary will have discretionary authority to determine whether and to what extent participants and beneficiaries are entitled to benefits and to construe disputed or doubtful Plan terms. The named Fiduciary will be deemed to have properly exercised such authority unless it has abused its discretion hereunder by acting arbitrarily and capriciously.

Increases/Decreases in Coverage: Any amendments to the Plan providing an increase in the amount of a covered Retiree's and/or Dependent's coverage will become effective as of the effective date stated in such amendment, provided coverage is in effect on that date. Any amendment to the Plan providing a decrease in the amount of a covered Retiree's and/or Dependent's coverage will begin on the effective date stated in such amendment.

Invalidity of Certain Provisions: If any provisions of the Plan will be held invalid or unenforceable, such invalidity or enforceability will not affect any other provision herein and this Plan will be construed and enforced as if such provisions had not been included.

Right to Make Payments: The Plan Administrator has the right to pay any other organization as needed to properly deliver Plan benefits. These Payments that are made in good faith are considered benefits paid under this Plan. Also, they discharge the Plan and the Plan Administrator from further liability to the extent that Payments are made.

Right to Receive and Release Necessary Information: For the purpose of determining the applicability of and implementing the terms of this provision of this Plan, or any provision of similar purpose of another Plan, the Contract Administrator or Plan Administrator may release to or obtain from any other insurance company or other organization or person any information with respect to any person which the Contract Administrator or Plan Administrator deems to be necessary for such purposes. Any person claiming benefits under this Plan will furnish to the Contract Administrator or Plan Administrator such information as may be required to implement this provision in accordance with the HIPAA Privacy Requirements.

Right to Recovery: Whenever the Plan has allowed benefits to be paid which have been paid or should have been paid by any other Plan, or which were erroneously paid, the Plan will have the right to recover any such excess Payments from the appropriate party.

Right to Amend the Plan: The Board of Trustees of USNH, or Plan Administrator, as authorized in writing by the Plan Sponsor, has the authority to amend this Plan Document, modifying any of the provisions herein, or terminating the Plan at any time without the consent of or notice to any Covered Person hereunder. The Plan may be amended, modified, or terminated to address Plan utilization, costs, market forces, federal legislation, or other general business concerns of the Plan Sponsor. When a Plan amendment, modification, or termination is executed, the Plan Sponsor will provide notice of such action, in writing, to all Covered Persons as required by applicable law.

Should the Plan be amended and, thereby, terminated, the Plan Administrator will provide for:

- First: Payment of benefits to each Covered Person of all covered Expenses for services which were incurred while the Plan was in effect.
- Second: Payment of Expenses incurred in the liquidation and distribution of the Plan and any Payments due to the Plan Administrator.
- Third: Direct disposition of all assets, if applicable, held in the Plan to Covered Persons as determined by the Plan Administrator, subject to the limitations contained herein and any applicable requirements of law or regulation.

The Use and Disclosure of Protected Health Information:

A. Uses and Disclosure of Protected Health Information (PHI)

The Plan will use and/or disclose Protected Health Information (PHI) (as such term is defined in the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Privacy and Security Rules promulgated thereunder at 45 C.F.R. Parts 160 and 164 (the HIPAA Privacy Requirements) to the extent of and in accordance with the uses and disclosures permitted or required by the HIPAA Privacy Requirements. Specifically, to the extent allowed by law, the Plan will use and disclose PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. To the extent not defined in this Plan Document, terms used in this Use and Disclosure of Protected Health Information section will be defined as stated in the HIPAA Privacy Requirements. The Plan Administrator will adopt policies and provide forms as it deems advisable to implement this section.

B. The Plan Will Use and Disclose PHI in accordance with and as Required by Law and as Permitted by Authorization of the Plan Participant or Beneficiary

The Plan will disclose PHI in accordance with and as permitted or required by law. For example, (i) the Plan may disclose summary health information to the Plan Sponsor if the Plan Sponsor requests the summary information for the purpose of obtaining premium bids for health insurance coverage under the Plan, or for modifying, amending or terminating the Plan; (ii) the Plan may disclose to the Plan Sponsor information on whether an individual is participating in the Plan or is enrolled in or has disenrolled from a health insurance issuer or HMO offered by the Plan; and (iii) to the extent allowed by law, the Plan may use and disclose PHI for purposes related to health care Treatment, Payment for health care, and Health Care Operations. Except for the uses and disclosures permitted or required by HIPAA, the Plan shall obtain a written authorization from the individual who is the subject of the PHI prior to a disclosure. "Summary health information" means information that may be individually identifiable health information and that summarizes the claims history, claims Expenses, or type of claims experienced by

individuals for whom the Plan Sponsor has provided health benefits under the Plan; and from which identifying information has been deleted, except that geographic information may be aggregated at the level of a five digit zip code.

C. Plan Sponsor Certification

The Employer (as Plan Sponsor) has delivered a certification to the privacy official for the Plan (as identified by the Employer) stating that this section has been amended into this Plan Document, that the Employer agrees to the terms of this section (including D, below), and identifying the group of designated Employees in E, below, who can use or disclose PHI for Plan administration purposes.

D. With Respect to PHI, the Plan Sponsor Agrees to the Following Conditions

The Plan Sponsor agrees to:

- not use or further disclose PHI other than as permitted or required by the Plan Documents or as required by law;
- ensure that any agents, including a subcontractor, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such PHI, including implementation of reasonable and appropriate security measures to protect the information;
- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual in accordance with HIPAA;
- not use or disclose PHI in connection with any other benefit or Employee benefit Plan of the Plan Sponsor unless authorized by an individual in accordance with HIPAA;
- report to the Plan any PHI use or disclosure that is inconsistent with the uses or disclosures provided for and any security incident of which it becomes aware;
- make PHI available to an individual in accordance with HIPAA's access requirements under 45 C.F.R. Section 164.524;
- make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA under 45 C.F.R. Section 164.526;
- make available the information required to provide an accounting of disclosures in accordance with HIPAA under 45 C.F.R. Section 164.528;
- make internal practices, books and records relating to the use and disclosure of PHI received from the Plan available to the U.S. Secretary of Health and Human Services for the purposes of determining the Plan's compliance with HIPAA; and
- if feasible, return or destroy all PHI received from the Plan that the Plan Sponsor still maintains in any form, and retain no copies of such PHI when no longer needed for the purpose for which disclosure was made (or if return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction infeasible);
- ensure there is adequate separation between the Plan Sponsor and the Plan, as described below, that is supported by reasonable and appropriate security measures; and
- implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic Protected Health Information that it creates, receives, maintains, or transmits on behalf of the Plan.

E. Adequate Separation Between the Plan and the Plan Sponsor Must Be Maintained

In accordance with HIPAA, the following Employees, classes of Employees or other persons under the Plan Sponsor's control may have access to PHI including PHI relating to Payment under, Health Care Operations of, or other matters pertaining to the administration of the Plan in the ordinary course of business:

Associate Director of Human Resources

Staff designated by the Associate Director of Human Resources

Finance Controller or staff designated by the Finance Controller

Director of Internal Audit or staff designated by the Director of Internal Audit

General Counsel or staff designated by the General Counsel

F. Limitations of PHI Access and Disclosure

The Plan may disclose PHI to the Plan Sponsor (via the persons described in section E), and the Plan Sponsor may use and further disclose such PHI, only when the Plan Sponsor is either: (i) performing Plan administration functions that the Plan Sponsor performs for the Plan or (ii) acting on behalf of the Plan; provided that the Plan Sponsor may only use or disclose PHI to the same extent as would be permitted by the Plan under the HIPAA regulations.

G. Noncompliance Issues

If Plan Sponsor personnel described in section E above do not comply with this Plan Document, the Plan Sponsor shall provide a mechanism for resolving any privacy or security related issues of noncompliance, including but not limited to disciplinary sanctions.

H. Security Requirements

The security rule under the HIPAA Privacy Requirements requires Plans to comply with four (4) general requirements. The Plan must:

- ensure the confidentiality, integrity, and availability of all electronic Protected Health Information that it creates, receives, maintains, or transmits;
- protect against any reasonably anticipated threats or hazards to the security or integrity of the electronic Protected Health Information;
- protect against any reasonably anticipated uses or disclosures of electronic Protected Health Information that are not permitted or required under HIPAA; and
- ensure compliance with the security standards by its workforce.

SUBROGATION, REIMBURSEMENT & THIRD-PARTY RECOVERY PROVISION

Payment Condition

1. The Plan, in its sole discretion, may elect to conditionally advance Payment of benefits in either of the following situations where an Injury, Illness, or disability is caused in whole or in part by, or results from the acts or omissions of Covered Persons, and/or their Dependents, beneficiaries, estate, heirs, guardian, personal representative, or assigns (collectively referred to hereinafter in this section as "Covered Person(s)") or a third party, or where any party besides the Plan may be responsible for Expenses arising from an incident, and/or other funds are available, including but not limited to no-fault, uninsured motorist, underinsured motorist, medical Payment provisions, third party assets, third party insurance, and/or guarantor(s) of a third party (collectively "Coverage").
2. Covered Person(s), his or her attorney, and/or legal guardian of a minor or incapacitated individual agrees that acceptance of the Plan's conditional Payment of medical benefits is constructive notice of these provisions in their entirety and agrees to maintain 100% of the Plan's conditional Payment of benefits or the full extent of Payment from any one or combination of first and third party sources in trust, without disruption except for reimbursement to the Plan or the Plan's assignee. The Plan shall have an equitable lien on any funds received by the Covered Person(s) and/or their attorney from any source and said funds shall be held in trust until such time as the obligations under this provision are fully satisfied. The Covered Person(s) agrees to include the Plan's name as a co-payee on any and all settlement drafts. Further, by accepting benefits the Covered Person(s) understands that any recovery obtained pursuant to this section is an asset of the Plan to the extent of the amount of benefits paid by the Plan and that the Covered Person shall be a trustee over those Plan assets.
3. In the event a Covered Person(s) settles, recovers, or is reimbursed by any Coverage, the Covered Person(s) agrees to reimburse the Plan for all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s). When such a recovery does not include Payment for future Treatment, the Plan's right to reimbursement extends to all benefits paid or that will be paid by the Plan on behalf of the Covered Person(s) for charges Incurred up to the date such Coverage or third party is fully released from liability, including any such charges not yet submitted to the Plan. If the Covered Person(s) fails to reimburse the Plan out of any judgment or settlement received, the Covered Person(s) will be responsible for any and all Expenses (fees and costs) associated with the Plan's attempt to recover such money. Nothing herein shall be construed as prohibiting the Plan from claiming reimbursement for charges Incurred after the date of settlement if such recovery provides for consideration of future medical Expenses.
4. If there is more than one party responsible for charges paid by the Plan, or may be responsible for charges paid by the Plan, the Plan will not be required to select a particular party from whom reimbursement is due. Furthermore, unallocated settlement funds meant to compensate multiple injured parties of which the Covered Person(s) is/are only one or a few, that unallocated settlement fund is considered designated as an "identifiable" fund from which the Plan may seek reimbursement.

Subrogation

1. As a condition to participating in and receiving benefits under this Plan, the Covered Person(s) agrees to assign to the Plan the right to subrogate and pursue any and all claims, causes of action or rights that may arise against any person, corporation and/or entity and to any Coverage to which the Covered Person(s) is entitled, regardless of how classified or characterized, at the Plan's discretion, if the Covered Person(s) fails to so pursue said rights and/or action.
2. If a Covered Person(s) receives or becomes entitled to receive benefits, an automatic equitable lien attaches in favor of the Plan to any claim, which any Covered Person(s) may have against any Coverage and/or party causing the Illness or Injury to the extent of such conditional Payment by the Plan plus reasonable costs of collection. The Covered Person is obligated to notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds. The Covered Person is also obligated to hold any and all funds so received in trust on the Plan's behalf and function as a trustee as it applies to those funds until the Plan's rights described herein are honored and the Plan is reimbursed.
3. The Plan may, at its discretion, in its own name or in the name of the Covered Person(s) commence a proceeding or pursue a claim against any party or Coverage for the recovery of all damages to the full extent of the value of any such benefits or conditional Payments advanced by the Plan.
4. If the Covered Person(s) fails to file a claim or pursue damages against:
 - a. The responsible party, its insurer, or any other source on behalf of that party;
 - b. Any first party insurance through medical Payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage;
 - c. Any policy of insurance from any insurance company or guarantor of a third party;
 - d. Workers' 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;

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

Right of Reimbursement

1. The Plan shall be entitled to recover 100% of the benefits paid or payable benefits Incurred, that have been paid and/or will be paid by the Plan, or were otherwise Incurred by the Covered Person(s) prior to and until the release from liability of the liable entity, as applicable, without deduction for attorneys' fees and costs or application of the common fund doctrine, make whole doctrine, or any other

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

2. No court costs, experts' fees, attorneys' fees, filing fees, or other costs or Expenses of litigation may be deducted from the Plan's recovery without the prior, express written consent of the Plan.
3. The Plan's right of subrogation and reimbursement will not be reduced or affected as a result of any fault or claim on the part of the Covered Person(s), whether under the doctrines of causation, comparative fault or contributory negligence, or other similar doctrine in law. Accordingly, any lien reduction statutes, which attempt to apply such laws and reduce a subrogating Plan's recovery will not be applicable to the Plan and will not reduce the Plan's reimbursement rights.
4. These rights of subrogation and reimbursement shall apply without regard to whether any separate written acknowledgment of these rights is required by the Plan and signed by the Covered Person(s).
5. This provision shall not limit any other remedies of the Plan provided by law. These rights of subrogation and reimbursement shall apply without regard to the location of the event that led to or caused the applicable Illness, Injury, or disability.

Covered Person is a Trustee Over Plan Assets

1. Any Covered Person who receives benefits and is therefore subject to the terms of this section is hereby deemed a recipient and holder of Plan assets and is therefore deemed a trustee of the Plan solely as it relates to possession of any funds which may be owed to the Plan as a result of any settlement, judgment or recovery through any other means arising from any Injury or accident. By virtue of this status, the Covered Person understands that he/she is required to:
 - a. notify the Plan or its authorized representative of any settlement prior to finalization of the settlement, execution of a release, or receipt of applicable funds;
 - b. instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on all settlement drafts;

- c. in circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement, judgment or other source of Coverage to include the Plan or its authorized representative as a payee on the settlement draft; and,
 - d. Hold any and all funds so received in trust, on the Plan's behalf, and function as a trustee as it applies to those funds, until the Plan's rights described herein are honored and the Plan is reimbursed.
2. To the extent the Covered Person disputes this obligation to the Plan under this section, the Covered Person or any of its agents or representatives is also required to hold any/all settlement funds, including the entire settlement if the settlement is less than the Plan's interests, and without reduction in consideration of attorneys fees, for which he/she exercises control, in an account segregated from their general accounts or general assets until such time as the dispute is resolved.
3. No Covered Person, beneficiary, or the agents or representatives thereof, exercising control over Plan assets and incurring trustee responsibility in accordance with this section will have any authority to accept any reduction of the Plan's interest on the Plan's behalf.

Release of Liability

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

Excess Insurance

If at the time of Injury, Illness, 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 otherwise provided for under the Plan's Coordination of Benefits section.

The Plan's benefits shall be excess to any of the following:

1. The responsible party, its insurer, or any other source on behalf of that party.
2. Any first party insurance through medical Payment coverage, personal Injury protection, no-fault coverage, uninsured or underinsured motorist coverage.
3. Any policy of insurance from any insurance company or guarantor of a third party.
4. Workers' compensation or other liability insurance company.
5. Any other source, including but not limited to crime victim restitution funds, any medical, disability or other benefit Payments, and school insurance coverage.

Separation of Funds

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

Wrongful Death

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

Obligations

1. It is the Covered Person's/Covered Persons' 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, disability, or Injury, including accident reports, settlement information and any other requested additional information.
 - c. To take such action and execute such documents as the Plan may require to facilitate enforcement of its subrogation and reimbursement rights.
 - d. To do nothing to prejudice the Plan's rights of subrogation and reimbursement.
 - e. To promptly reimburse the Plan when a recovery through settlement, judgment, award, or other Payment is received.
 - f. To notify the Plan or its authorized representative of any incident related claims or care which may be not identified within the lien (but has been Incurred) and/or reimbursement request submitted by or on behalf of the Plan.
 - g. To notify the Plan or its authorized representative of any settlement prior to finalization of the settlement.
 - h. To not settle or release, without the prior consent of the Plan, any claim to the extent that the Covered Person may have against any responsible party or Coverage.
 - i. To instruct his/her attorney to ensure that the Plan and/or its authorized representative is included as a payee on any settlement draft.
 - j. In circumstances where the Covered Person is not represented by an attorney, instruct the insurance company or any third party from whom the Covered Person obtains a settlement to include the Plan or its authorized representative as a payee on the settlement draft.
 - k. To make good faith efforts to prevent disbursement of settlement funds until such time as any dispute between the Plan and Covered Person over settlement funds is resolved.

2. If the Covered Person(s) and/or his or her attorney fails to reimburse the Plan for all benefits paid or to be paid, incurred, or that will be incurred, prior to the date of the release of liability from the Relevant entity, as a result of said Injury or condition, out of any proceeds, judgment or settlement received, the Covered Person(s) will be responsible for any and all Expenses (whether fees or costs) associated with the Plan's attempt to recover such money from the Covered Person(s).
3. The Plan's rights to reimbursement and/or subrogation are in no way Dependent upon the Covered Person's/Covered Persons' cooperation or adherence to these terms.

Offset

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

Minor Status

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

Language Interpretation

The Plan Administrator retains sole, full, and final discretionary authority to construe and interpret the language of this Plan Document, to determine all questions of fact and law arising under this Plan Document, and to administer the Plan's rights with respect to this Plan Document. The words "herein" and "hereunder" used in this Plan Document shall mean this Plan Document. Whenever a noun or pronoun is used in this Plan Document in plural form and there is only one person within the scope of the word so used, or in singular form and there be more than one person within the scope of the word so used, such word or pronoun shall have a plural or singular meaning as the case may be. Headings are given to the sections only for the purpose of convenience and to make the document easier to read. Headings, numbering, and paragraphing shall not in any case be deemed material or Relevant to the interpretation of this Plan Document.

Severability

In the event that any section of this Plan Document 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.

DEFINITIONS

The following words and phrases are included here for explanatory purposes only. This list is not intended to include all terms used herein. Any word or phrase not specifically defined below will have its usual and customary meaning. The inclusion of any word or phrase below is not intended to imply that coverage is provided under the Plan with respect to any such condition, service, facility, or person.

Ambulatory Surgical Center: A facility which is not physically attached to a health care facility, which provides surgical Treatment to patients not requiring hospitalization, and does not include the offices of private Physicians or Dentists whether in an individual or group practice.

Civil Union Partner: A legal union of a same-sex couple, documented by an authorized person in the state in which the Retiree and partner reside. A Civil Union will be required as of January 1, 2010 to be covered under the Plan.

Clinical Trial: A Clinical Trial that meets the following conditions:

1. The Clinical Trial is intended to treat cancer in a patient who has been diagnosed; and
2. The Clinical Trial has been peer reviewed and is approved by at least one of the following:
 - a. National Institutes of Health,
 - b. A cooperative group or center of the National Institutes of Health.
 - c. A qualified non-governmental research entity identified in guidelines issued by the National Institutes of Health for center support grants,
 - d. The United States Food and Drug Administration pursuant to an Investigational new drug exemption,
 - e. The United States Department of Defense of Veterans Affairs,
 - f. Or, with respect to Phase II, III and IV Clinical Trials, a qualified institutional review board.
3. The facility and personnel conducting the Clinical Trial are capable of doing so by virtue of their experience and training and treat a sufficient volume of patients to maintain that expertise, and
4. The patient meets the patient selection criteria enunciated in the study protocol for participation in the Clinical Trial, and
5. The patient has provided informed consent for participation in the Clinical Trial in a manner that is consistent with current legal and ethical standards, and
6. The available clinical or pre-clinical data provide a reasonable expectation that the patient's participation in the Clinical Trial will provide a medical benefit that is commensurate with the risks of participation in the Clinical Trial, and
7. The Clinical Trial must have a therapeutic intent and must, to some extent, assess the effect of the intervention on the patient.

Coinsurance: Coinsurance percentages represent the portions of covered Expenses paid by the Covered Person and by the Plan after satisfaction of any applicable Deductible. These percentages apply only to the portion of the covered Expenses which do not exceed the Reasonable and Customary Charges. The Covered Person is responsible for all non-covered Expenses and any amount which exceeds the Reasonable and Customary Charges for covered Expenses, except to the extent prohibited by applicable law.

Contract Administrator: Employee Benefit Plan Administration, LLC dba Employee Benefit Plan Administration (EBPA), which is a third-party claims administrator, hired by the Plan Sponsor to handle the day-to-day administration of the Plan, including:

1. reviewing and processing claims for proper benefit Payments and providing explanation of benefits to covered Retirees and/or providers;
2. remitting benefit Payments for covered Expenses under the Plan to covered Retirees and/or providers;
3. reviewing all claims appeals.

Contributory Coverage: Plan benefits for which a Retiree enrolls and agrees to make any required contributions toward the cost of coverage.

Convalescent Hospital/Extended Care Facility/Skilled Nursing Facility: An institution which is licensed pursuant to state and/or local laws and is operated primarily for the purpose of providing Treatment for individuals convalescing from Injury or Illness, including that part or unit of a Hospital which is similarly constituted and operated, and:

1. Has organized facilities for medical Treatment and provides for twenty-four (24) hour nursing service under the full-time supervision of a Physician or a registered nurse. Full-time supervision means a Physician or a registered nurse is regularly on the premises at least forty (40) hours per week;
2. Maintains daily clinical records concerning each patient and has a written agreement or arrangement with a Physician to provide services and emergency care for its patients;
3. Provides appropriate methods for dispensing and administering drugs and medicines;
4. Has transfer agreements with one (1) or more Hospitals, a utilization review procedures in effect, and operational policies developed with the advice of and reviewed by a professional group including at least one (1) Physician. A Convalescent Hospital/Extended Care Facility will not include any institution which is a rest home for the aged, or a place for the Treatment of mental disease, drug addiction or alcoholism, or a nursing home.
5. Qualifies as an "Extended Care Facility" under the health insurance provided by Title XVIII of the Social Security Act, at the time.

Copayment: A fixed amount of money that is paid each time a particular service is used. There may be Copayments on some services and not on other services.

Covered Person: A covered Retiree, spouse, Civil Union Partner, disabled Dependent age sixty-five (65) or over, and others as determined by the Employer.

Custodial Care: Care which is designed essentially to help a person in the activities of daily living and which does not require the continuous attention of trained medical or paramedical personnel. Custodial Care includes services that could be performed by a relative or friend with minimal instruction or supervision.

Day of Confinement: Any period of twenty-four (24) hours or any part thereof for which a full charge for room and board is made by a Hospital.

Deductible: The dollar amount of covered Expenses the covered Employee must pay during each calendar year before the Plan will begin paying for covered Expenses. The individual Deductible applies separately to each Covered Person. The family Deductible is the maximum Deductible applied to each family. When the family Deductible is satisfied, no further Deductible will be applied for any covered family member during the remainder of that calendar year.

Dental Services: Procedures involving the teeth, gums, or supporting structures.

Dentist: A duly licensed doctor of dentistry and a dental professional or practitioner who is duly licensed under appropriate state licensing authorities, provided a benefit is claimed for services which are within the scope of such person's license and for which a reimbursement under the Plan would be made had such services been performed by a doctor of dentistry, and under applicable state laws, such professional or practitioner must be treated under the Plan in the same manner as if such services were provided by a doctor of dentistry.

Dependent:

1. The lawful spouse, Civil Union Partner, or Same-Sex Domestic Partner at the time of retirement of an eligible Retiree. To qualify for Same-Sex Domestic Partnership coverage, you must file an Affidavit of Same-Sex Domestic Partnership with the UNH Benefits Office and provide any additional required documentation prior to January 1, 2010. As of January 1, 2010, same-sex partners need to be in a legally recognized Civil Union in order to be eligible for coverage under this Plan; or
2. the disabled child of an eligible Retiree over age sixty-five (65).

Should a Retiree have a child who is mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider the child as a Dependent, while the child remains in such condition, subject to all of the terms of the Plan, provided the Retiree has submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

Effective Date of Coverage: The date a Retiree and/or their Dependent(s) become eligible to enroll in the Plan.

Employer: University System of New Hampshire and any affiliate permitted by University System of New Hampshire to provide coverage to its Employees under this Plan.

Expense: A charge a Covered Person is legally obligated to pay. An Expense is deemed to be incurred on the date the service or supply is furnished.

Experimental/Investigative: A drug, device, medical Treatment, or procedure that is not the subject of, or in some manner related to, the conduct of a Clinical Trial, as such term is defined herein, is Experimental or Investigative:

- 1) if the drug or device 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 or device is furnished; or
- 2) if the drug, device, medical Treatment or procedure, or the patient informed consent document utilized with the drug, device, Treatment, or procedure, was reviewed, and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or
- 3) if reliable evidence shows that the drug, device, medical Treatment, or procedures 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; or
- 4) if reliable evidence shows that the prevailing opinion among experts regarding the drug, device, medical Treatment, or procedure 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.

For purposes of this definition, 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, or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical Treatment, or procedure.

Fiduciary: A Fiduciary exercises discretionary authority or control over management of the Plan or the disposition of its assets; renders investment advice to the Plan; or has discretionary authority or responsibility in the administration of the Plan.

Health Care Operations: include, but are not limited to the following activities, in accordance with the HIPAA Privacy Requirements:

- quality assessment;
- population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting health care providers and patients with information about Treatment alternatives and related functions;
- rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities;
- underwriting, premium rating and other activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to health care claims (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs;
- business planning and development, such as conducting cost-management and planning-related analyses related to managing and operating the Plan, including formulary development and administration, development or improvement of Payment methods or coverage policies;
- business management and general administrative activities of the Plan, including, but not limited to:

- a) management activities relating to the implementation of and compliance with HIPAA's administrative simplification requirements, or
- b) customer service, including the provision of data analyses for policyholders, Plan Sponsors, or other customers;
- resolution of internal grievances;
- the sale, transfer, merger, or consolidation of all or part of the "covered entity" within the meaning of HIPAA with another covered entity, or an entity that following such activity will become a covered entity and due diligence related to such activity; and
- consistent with the applicable requirements of the regulations issued under HIPAA, creating de-identified health information or a limited data set, and fundraising for the benefit of the "covered entity" within the meaning of HIPAA.

Health Care Professional: A Physician or other Health Care Professional licensed, accredited, or certified to perform specified health services consistent with State law.

Home Health Care Agency: A licensed and state approved home health care facility possessing a valid certificate of approval issued in accordance with Title XVIII of the Social Security Act and licensed and approved by the appropriate state authorities which specializes in providing health care and therapeutic services to a person in such person's home.

Home Health Care Plan: A program for care and Treatment of a Covered Person established and approved, in writing, by such Covered Person's attending Physician, together with such Physician's certification that the proper Treatment of the Injury or Illness would require confinement as a resident inpatient in a Hospital or confinement in a Skilled Nursing Facility as defined in Title XVIII of the Social Security Act, at the time, in the absence of services and supplies provided as part of the Home Health Care Plan.

Hospice: An agency that provides counseling and incidental medical services for a terminally ill individual who has been diagnosed by a Physician as having a life expectancy of six (6) months or less. Room and board may be provided. The agency must meet all of the following tests: (i) approved under any required state or governmental Certificate of Need; (ii) provides twenty-four (24) hour a day, seven (7) day a week service; (iii) it is under the full-time supervision of at least one (1) duly qualified Physician; (iv) has a nurse coordinator who is a registered graduate nurse with at least four (4) years of full-time clinical experience. Two (2) of these years must involve caring for terminally ill patients; (v) has a social service coordinator who is licensed in the area in which it is located; (vi) the main purpose of the agency is to provide Hospice services; (vii) has a full-time administrator; (viii) maintains written records of services given to each patient; (ix) its employees are bonded; (x) it provides malpractice and malplacement insurance; (xi) is established and operated in accordance with any applicable state laws.

Hospital: A duly licensed, if required, and legally-constituted and operated institution which is primarily engaged in providing diagnostic services, therapeutic services for diagnosis, care and Treatment of sick or injured persons on an Inpatient and/or Outpatient Basis, and which provides such care and Treatment: (i) under the supervision of one (1) or more Physicians, (ii) with twenty-four (24) hour nursing service under the supervision of one (1) or more Physicians licensed to practice medicine; and (iii) which has organized facilities for laboratory and diagnostic work and major surgery. The term "Hospital" will not include, other than incidentally, an institution which is primarily a rest home, a nursing home, a convalescent home, a rehabilitation center, an Extended Care Facility, a place (primarily) for the Treatment of tuberculosis, mental, emotional, drug or alcoholic disorders, or a home for the aged. Services rendered in the infirmary or clinic of a college, university, or private boarding school will be eligible Expenses. In such instances, if a

Covered Person is confined in a school facility that does not meet the definition of a Hospital because it has no operating room, benefits may be paid, provided the charges for such confinement do not exceed the Reasonable and Customary Charges for the Illness or Injury involved.

Hospital Confinement: Being registered as a bed-patient in a Hospital upon the recommendation of a Physician, or as a result of a surgical operation, or by reason of receiving emergency medical care.

Illness: Sickness or disease which results in Expenses for medical care, services, and supplies covered by the Plan. Such Expenses must be incurred while the Covered Person, whose Illness is the basis of the claim, is covered under the Plan. Medical Expenses incurred by a Covered Person because of pregnancy will be covered to the same extent as any other Illness.

Injury: Accidental bodily harm resulting from an accident, which results in Expenses for medical care, services, and supplies covered by the Plan. Such Expenses must be incurred while the Covered Person, whose Injury is the basis of the claim, is covered under the Plan.

Inpatient Basis: Hospital Confinement including one (1) or more days of confinement for which a room and board charge is made by a Hospital.

Intensive Care Unit: An accommodation in or part of a Hospital, other than a post-operative recovery room, which, in addition to providing room and board:

1. Is established by the Hospital for the purpose of providing formal intensive care;
2. Is exclusively reserved for critically ill patients requiring constant audio/visual observation prescribed by a Physician and performed by a Physician or by a specifically trained registered nurse; and
3. Provides all necessary lifesaving equipment, drugs, and supplies in the immediate vicinity on a standby basis.

Maximum Medical Lifetime Benefits: The maximum lifetime benefit amount under this Plan for all covered medical Expenses incurred by a Covered Person. See amounts on the "Schedule of Benefits".

Medical Emergency: The sudden, unexpected onset of a medical condition with severe symptoms that are considered hazardous to the patient's life, health, or physical well-being, requiring urgent and immediate medical attention.

Medical Intervention: Any medical Treatment, service procedure, facility, equipment, drug, device, or supply.

Medically Necessary: Health care services, supplies, or Treatment will be considered Medically Necessary if the Contract Administrator determines such service, supply, or Treatment to be:

- a) Appropriate and necessary for, and consistent with, the diagnosis or Treatment of the Illness or Injury;
- b) Provided for the diagnosis or direct care and Treatment of the Illness or Injury;
- c) Within generally accepted standards of good medical practice within the organized medical community;

- d) Not primarily for the convenience of the Covered Person, the Physician or other Provider, or the Hospital or other facility;
- e) Not more costly than an equivalent service or sequence of services that is medically appropriate and is likely to produce equivalent therapeutic or diagnostic results in regard to the diagnosis or Treatment of the Covered Person's Illness or Injury;
- f) The most appropriate service, supply, or Treatment which can safely be provided. The most appropriate service, supply, or Treatment must satisfy the following requirements:
 - there must be valid scientific evidence demonstrating that the expected health benefit from the service, supply, or Treatment are clinically significant and produce a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the Covered Person with the particular Illness or Injury being treated than other possible alternatives; and
 - generally accepted forms of service, supply, or Treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
 - for Hospital stays, acute care as an inpatient is necessary due to the kind of services the Covered Person is receiving or the severity of the Covered Person's condition, and safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

The Contract Administrator shall determine, in their sole and absolute discretion, whether a service, supplies, or Treatment is Medically Necessary under the Plan. Even though a Physician or other Provider may have prescribed a service, supplies, or Treatment, such service, supplies, or Treatment may not be Medically Necessary within this definition.

Mental Hospital: An institution (other than a Hospital as defined) which specializes in the diagnosis and Treatment of Mental Illness or functional nervous disorders and which is operated pursuant to law and meets all of the following requirements:

1. Is licensed to give medical Treatment and is operated under the supervision of a Physician;
2. Offers nursing services by registered graduate nurses (RN) or licensed practical nurses (LPN) and provides, on the premises, all the necessary facilities for medical Treatment;
3. Is not, other than incidentally, a place of rest or a place for the aged, drug addicts, or alcoholics; or a place for convalescent, custodial, or educational care.

Mental Illness: Neuroses, psychoneuroses, psychoses, and other mental and emotional disorders falling within any of the diagnostic categories in the mental disorders section of the international classification of diseases.

Out-of-Pocket Maximum Limit: Under the terms of this Plan, the maximum dollar amount of medical covered Expenses or prescription drug benefits, as applicable, that any individual covered under the Plan would be required to pay toward the Reasonable and Customary (R&C) allowance on all covered Expenses during a calendar year. Whether a Covered Person has met the applicable Out-of-Pocket Maximum Limit for the calendar year will be determined by adding the Deductible and Retiree share of Coinsurance amounts paid by the Retiree as set forth by this Plan.

Outpatient Basis: Any Hospital Expenses incurred for which no room and board charge is made.

Outpatient Mental Health Treatment Facility: A comprehensive, health service organization, a licensed or accredited Hospital, or community mental health center or other mental health clinic or day care center which furnished mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the diagnosis, evaluation, service or Treatment of Mental Illness or emotional disorder.

Payment: Includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for the coverage and provision of Plan benefits or to obtain or provide reimbursement for the provision of health care that relate to an individual to whom health care is provided. These activities include, but are not limited to, the following, in accordance with the HIPAA Privacy Requirements:

- determination of eligibility, coverage, and cost-sharing amounts (for example, cost of a benefit, Plan maximums and Copayments as determined for an individual's claim);
- coordination of benefits;
- adjudication of health benefit claims (including appeals and other Payment disputes);
- subrogation of health benefit claims;
- establishing Retiree contributions;
- risk adjusting amounts due based on enrollee health status and demographic characteristics;
- billing, collection activities and related health care data processing;
- claims management and related health care data processing, including auditing Payments, investigating, and resolving Payment disputes and responding to participant inquiries about Payments;
- obtaining Payment under a contract for reinsurance (including stop-loss and excess of loss insurance);
- medical necessity reviews or reviews of appropriateness of care or justification of charges;
- utilization review, including precertification, prior authorization, concurrent review, and retrospective review; and
- disclosure to consumer reporting agencies related to the collection of premiums or reimbursement (the following PHI may be disclosed for Payment purposes: name and address, date of birth, Social Security number, Payment history, account number and name and address of the provider and/or health Plan).

Physician: A duly licensed doctor of medicine (M.D.), a doctor of osteopathy (D.O.), a Dentist (D.M.D.) or D.D.S.), a psychologist, a podiatrist (Pod.D., D.S.C. or D.P.M.), an acupuncturist, an optometrist (O.D.), a pastoral counselor, and advanced registered nurse practitioner, an occupational therapist, a physical therapist, a speech therapist or a Physician's assistant, each being licensed or certified by the state in which services are being rendered and acting within the scope of their license. A licensed clinical social worker will be considered a "Physician" in those states in which it is mandatory that coverage be provided for their services. A licensed pastoral counselor is an individual who is licensed by the State of New Hampshire under RSA 330-B and who by virtue of professional education and experience would be eligible for fellowship in the American Association of Pastoral Counselors. "Physician" will also mean an authorized Christian Science Practitioner of the Mother Church, the First Church of Christ, Scientist, Boston, MA. This coverage is limited to practitioners and does not include "readers". Refer also to your Medicare Handbook for a current list of approved Physicians and special practitioners.

Plan: The University System of New Hampshire Medicare Complementary Plan, as described in this Plan Document.

Plan Administrator: University System of New Hampshire

Plan Anniversary Date: The date occurring in each calendar year which is an anniversary of the effective date of the Plan.

Plan Document: The master contract which describes the terms of coverage and association between the Contract Administrator and the Plan Sponsor.

Plan Effective Date: The date the Plan becomes liable to provide coverage under the terms of the Plan.

Plan Sponsor: University System of New Hampshire

Prior Plan: The prior group medical Plan, if any, offered by the Plan Sponsor.

Protected Health Information: Health information, including demographic information, which is collected from an individual, and which;

- is created or received by the Plan;
- relates to the past, present, or future physical or mental health or condition of an individual; the provision of health care to an individual; or the past, present, or future Payment for the provision of health care to an individual; and
 - a) that identifies the individual; or
 - b) with respect to which there is a reasonable basis to believe that the information can be used to identify the individual; and
- is transmitted by electronic media, maintained in any electronic medium, or transmitted or maintained in any other form or medium by a covered entity under the HIPAA Privacy Requirements. Protected Health Information excludes information in education records covered by the Family Educational Right and Privacy Act, records described at 20 U.S.C. 1232(g)(a)(4)(B)(iv), and employment records held by the Plan Sponsor in its role as Employer.

Reasonable and Customary Allowance (R&C): A maximum allowable charge for each covered medical and dental service provided for under the Plan, as established for this Plan, solely by a national firm. The following is used as a guide: This allowance schedule is intended to include all charges provided, in the geographical area where the covered Expense is incurred, by properly licensed medical and dental care providers, and which do not exceed the usual fees charged for comparable services. For the purposes of this Plan, the term Reasonable and Customary extends to a preferred provider negotiated fee allowance, where appropriate.

Rehabilitation Hospital: A facility which meets all requirements of a Hospital (as defined herein) other than the "surgical facilities" requirements and, in addition, meets the following criteria:

1. It must be accredited by the Joint Commission of Accreditation of Hospitals and be approved for Federal Medicare Benefits as a qualified Hospital;
2. It must maintain transfer agreements with acute care facilities to handle surgical and/or medical emergencies;
3. It must maintain a utilization review committee.

Rehabilitative Care: Medically Necessary inpatient medical care (as prescribed by a Physician) rendered in a Rehabilitation Hospital (as defined herein) excluding Custodial Care or occupational training.

Relevant: In the context of whether a document, record or other information shall be considered "Relevant," means the following: a document, record, or other information

- (i) relied upon in making the benefit determination;
- (ii) submitted, considered, or generated in the course of making the benefit determination, without regard to whether such document, record, or other information was relied upon in making the benefit determination;
- (iii) demonstrating compliance with the administrative processes and safeguards designed to ensure and to verify that benefit claim determinations are made in accordance with the governing Plan Documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated Claimants in making the benefit determination; or
- (iv) constituting a statement of policy of guidance with respect to the Plan concerning the denied Treatment option or benefit for the Claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

In no event should the provisions of this Claim Review Procedures section be interpreted to require any Claimant to file more than two (2) appeals of an Adverse Benefit Determination.

Residential Treatment Facility: A child care institution that provides residential care and Treatment for emotionally disturbed children and adolescents. The facility must be accredited as a Residential Treatment Facility by the Council on Accreditation of Hospitals or the American Association of Psychiatric Services for Children.

Retiree: Any Retirees who qualify for Retiree Coverage under the eligibility requirements set forth in the "General Information" section contained herein. The definition of a Retiree does not include independent contractors, contingent workers, or leased Retirees.

Retiree Coverage: Group medical benefits provided under the Plan on behalf of a covered Retiree.

Same-Sex Domestic Partner (only applies to Same-Sex Domestic Partners covered under the Plan as of December 31, 2009. Effective January 1, 2010, same-sex partners need to be in a legally recognized civil union in order to be eligible for coverage under the Plan):

1. Partners must be of the same gender;
2. Partners must be at least eighteen (18) years of age and are mentally competent to contract;
3. The partners are responsible for each other's common welfare and financial obligations;

4. The partnership must have been in existence for the past six (6) consecutive months and Plan to remain so indefinitely;
5. Partners are not legally married, cannot be related by blood to a degree that would prohibit marriage, nor allowed to marry each other in the state of New Hampshire.

Substance Abuse: Any use of alcohol or drugs which produces a state of psychological and/or physical dependence.

Substance Abuse Treatment Facility:

1. A public or private facility providing services especially for detoxification or rehabilitation of Substance Abuse and which is licensed to provide such services;
2. A comprehensive health service organization, community mental health clinic or day care center which furnishes mental health services with the approval of the appropriate governmental authority, any public or private facility or portion thereof providing services especially for the rehabilitation of Substance Abuse and which is licensed to provide such services.

Totally Disabled: The inability to work for wage or profit at any job for which you are reasonably qualified by education, training, or experience. Your covered Dependent will be considered Totally Disabled if, because of Illness or Injury, he cannot perform all normal activities of a person of the same age and sex in good health.

Treatment: The provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; and the referral of a patient for health care from one health care provider to another.

Waiting Period: The period of time between the Retiree's satisfaction the Plan's eligibility requirements and the Effective Date of Coverage under the Plan.

PLAN DOCUMENT ACCEPTANCE PAGE

APPROVED AND ACCEPTED

This Plan Document, known as the University System of New Hampshire Medicare Complementary Plan, is hereby executed at:

Concord
(City)

New Hampshire on
(State)

August 22, 2022
(Date)

BY: Jay Cushing

TITLE: Retiree + Trans. Support Spec.

SUMMARY of MATERIAL MODIFICATION

AMENDMENT # 1

to the

UNIVERSITY SYSTEM OF NEW HAMPSHIRE

MEDICARE COMPLEMENTARY PLAN

The University System of New Hampshire Medicare Complementary Plan is hereby amended, effective 09/01/22. This amendment affects all claims for services incurred on or after the effective date of this amendment. The terms of this amendment are as follows:

I. The "General Information" section will be replaced in its entirety with the attached.

II. Under the "Definitions" section, the corresponding items will be replaced in their entirety:

Covered Person: A covered Retiree, spouse, disabled Dependent age sixty-five (65) or over, and others as determined by the Employer.

Dependent:

1. The lawful spouse at the time of retirement of an eligible Retiree; or
2. the disabled child of an eligible Retiree over age sixty-five (65).

Should a Retiree have a child who is mentally or physically handicapped and incapable of earning his own living, the Plan will continue to consider the child as a Dependent, while the child remains in such condition, subject to all of the terms of the Plan, provided the Retiree has submitted proof of the child's incapacity, as described above.

The Plan Sponsor will have the right to require satisfactory proof of continuance of such mental or physical incapacity and the right to examine such child at any time after receiving proof of the child's incapacity. Upon failure to submit such required proof or to permit such an examination when requested by the Plan Sponsor, or when the child ceases to be so incapacitated, coverage with respect to the child will cease. This continuation of coverage will be subject to all the provisions of the "Termination of Benefits" section of this Plan except as modified herein.

III. Under the "Definitions" section, the corresponding items will be deleted in their entirety:

Civil Union Partner: A legal union of a same-sex couple, documented by an authorized person in the state in which the Retiree and partner reside. A Civil Union will be required as of January 1, 2010 to be covered under the Plan.

Same-Sex Domestic Partner (only applies to Same-Sex Domestic Partners covered under the Plan as of December 31, 2009. Effective January 1, 2010, same-sex partners need to be in a legally recognized civil union in order to be eligible for coverage under the Plan):

1. Partners must be of the same gender;
2. Partners must be at least eighteen (18) years of age and are mentally competent to contract;
3. The partners are responsible for each other's common welfare and financial obligations;

- 4. The partnership must have been in existence for the past six (6) consecutive months and Plan to remain so indefinitely;
- 5. Partners are not legally married, cannot be related by blood to a degree that would prohibit marriage, nor allowed to marry each other in the state of New Hampshire.

APPROVED AND ACCEPTED

This Plan Amendment # 1 to the University of New Hampshire Medicare Complementary Plan, is hereby executed:

Concord
(City)

NH on 9/20/2022
(State) (Date)

BY: Jay Cushing
Retiree + Trans. Support Spec.
(Title)

GENERAL INFORMATION

Name of the Plan: University System of New Hampshire Medicare Complementary Plan

Plan Sponsor/Plan Administrator: University System of New Hampshire
5 Chenell Drive, Suite 301
Concord, NH 03301
(603) 862-1800

Plan Number: 501

Contract Administrator Group Number: 10200

Plan(s) Covered: The Plan is a welfare Plan providing medical and prescription drug coverage.

Plan Sponsor's Federal Tax Identification Number: 02-6000937

Plan Effective Date: January 1, 1988

Plan Anniversary Date: January 1st

Plan Year Ends: December 31st

Plan Revision Date: September 1, 2022 – This document replaces the previous Employee Benefit Plan Summary Plan Description and Plan Document in its entirety. All claims incurred prior to September 1, 2022 will be governed by the terms of the Plan in effect prior to this revision date.

Contract Administrator/Pre-Certification Administrator:

Employee Benefit Plan Administration, LLC dba Employee Benefit Plan
Administration (EBPA)
P.O. Box 2000
Exeter, NH 03833-2000
Customer Service: (603) 778-7106 or (800) 578-3272 (EBPA)
Pre-Certification: (800) 204-5990

Agency for Service of Legal Process: University System of New Hampshire
5 Chenell Drive, Suite 301
Concord, NH 03301

Service of process may also be made upon the Plan Administrator.

Contributions: The Plan provides Contributory Coverage, meaning that Employees must contribute towards the cost of coverage under the Plan. The Plan Sponsor will determine the amount of contributions that Employees will be required to pay for coverage each year, in its sole discretion but subject to applicable law. The Plan Sponsor will be responsible for any amounts in excess of the contributions required by Employees. Operating Expenses may be paid out of Plan Sponsor and/or Employee contributions.

Eligibility Requirements: Retired faculty or staff members age sixty-five (65) or over who elected to retain Retiree medical coverage at age sixty-five (65); their spouses, their disabled Dependents age sixty-five (65) or over and others as determined by the Employer at the time of initial enrollment into the Plan. Contact the University System of New Hampshire Benefits Office for information on eligibility and for more information regarding this Plan.

IMPORTANT NOTE: The benefits of the Medicare Complementary Plan will automatically be adjusted to accommodate changes in Medicare benefits.

Effective Date of Coverage: The first day of the month that the Retiree turns age sixty-five (65) or becomes Medicare eligible.

Termination Date: See "Termination of Benefits" section.

What is a Medicare Complementary Plan?

A Medicare Complementary Plan is coverage which supplements Medicare approved benefits and also provides limited Major Medical benefits.

Part A of Medicare helps pay for inpatient Hospital or Skilled Nursing Facility care and related inpatient Expenses, home health care and Hospice care. Part B helps pay for doctor's services, outpatient Hospital services, durable medical equipment and other services and supplies not covered under Part A. Medicare Deductible and Copayment amounts and eligible benefits vary each year, so refer to a current Medicare Handbook for further information and requirements.

When Should I enroll in Medicare?

Medicare becomes available at the beginning of the month in which you turn sixty-five (65) whether you are retired or still working. You automatically apply for Medicare when you apply for Social Security benefits. If you plan to work past age sixty-five (65), you should apply for Medicare Part A when you turn sixty-five (65). You should apply for Medicare Part B when you actually retire. You must be enrolled in both Medicare Parts A and B to be eligible for full coverage under this Medicare Complementary Plan. If you are eligible for Medicare Parts A and B, but have not enrolled, benefits will be payable at the same level as if you were receiving full Medicare benefits.