Liberty Mutual Health Plan
Summary Plan Description
(SPD Version For Eligible Retirees Age 65 And Older Medical with Prescription Drug Option)
(For U.S. Employees Only)

Effective January 1, 2017
HEALTH PLAN
(SPD Version For Eligible Retirees Age 65 And Older - Medical with Prescription Drug Option)

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HEALTH PLAN
(SPD Version for Eligible Retirees Age 65 and Older - Medical with Prescription Drug Option)

Overview

If you are covered by the Liberty Mutual Health Plan (the “Plan”) immediately prior to your retirement, you retire at age 65 or older, and you have at least 10 years of employment, you may continue medical coverage after retirement by electing either retiree coverage or COBRA coverage.

For purposes of this Summary Plan Description, the following terms shall have the following meanings: “Company” means Liberty Mutual Group Inc.; “Participating Employers” means the Company and its subsidiaries that participate in the Plan. Please note: This Summary Plan Description describes the options available only to retirees and eligible dependents who are age 65 and older. The Summary Plan Descriptions describing the options for retirees and eligible dependents younger than age 65 are available by calling Benefits Express at 1-800-758-4460.

As a retiree age 65 or older at the time of retirement, you will need to elect a coverage option and category at the time of retirement. You may not defer your election to a later date. It is important that you give this decision careful consideration because this is the only time that you may enroll. Current options available include:

- No coverage – once this election is made, coverage cannot be elected in the future
- Medical with Prescription Drug option. You must be eligible for Medicare to participate in this option.
- Medical Only option – once this election is made, the Medical with Prescription Drug option cannot be elected in the future. You must be eligible for Medicare to participate in this option.

Detailed information on the Medical with Prescription Drug option is found in this Summary Plan Description. Detailed information on the Medical Only option for retirees age 65 and older is found in a separate Summary Plan Description, which may be obtained by calling Benefits Express at 1-800-758-4460.

Please note: If you elect coverage for yourself and your spouse or domestic partner, and your spouse or domestic partner is younger than age 65, then your spouse or domestic partner must enroll in one of the options available to participants younger than age 65 and you, the retiree, must select from the options available to participants age 65 and older. If a retiree or covered dependent upon reaching age 65 or becoming Medicare eligible elects the Medical Only option, this election will apply to all participants upon reaching Medicare eligibility with no opportunity to change to the Medical with Prescription Drug option in the future.

A Self-Insured Plan
The Liberty Mutual Health Plan is a "self-insured" plan. This means that health care claims are paid from the Company’s general assets. The money used to pay the claims comes from your contributions for coverage and the Company’s contributions.
Health Plan Options

Medical with Prescription Drug
As a retiree who is age 65 or older, you are eligible for the Medical with Prescription Drug option. Under this option, preventive care expenses are covered at 100% with no deductible. You pay a $200 charge per visit for use of an emergency room. The $200 charge is paid before the deductible or any coinsurance and does not count towards the annual deductible or out-of-pocket maximum. The $200 charge is not waived if you are admitted to the hospital. You continue to pay your deductible and 80% coinsurance of the Reasonable & Customary (R&C) amount. Other Covered Health Care Expenses are paid at 80% of the R&C amount after you meet the $300 annual individual deductible ($600 retiree and spouse or retiree and domestic partner deductible, $900 family deductible), with special limits applying to certain charges. To protect against unusually high expenses, the Plan also includes an annual out-of-pocket maximum. If your out-of-pocket expenses (deductible plus 20% coinsurance) reach the $1,500 per individual, $3,000 per retiree and spouse or retiree and domestic partner, or $4,500 per family maximum in any given calendar year, the Plan will pay 100% of any remaining covered expenses for that year. Note that because you are eligible for Medicare Parts A and B coverage, Medicare is primary. Please refer to the “Medicare” and “Non-Duplication of Benefits” sections later in this Summary Plan Description for detailed information. UnitedHealthcare is the claims administrator for this option. You can reach them directly at 1-844-542-6884. Participants who elect this option will also participate in the prescription drug program through SilverScript® Insurance Company and administered by CVS/caremark.

No Coverage
At the time you retire, you may elect to not enroll in medical coverage. If you are age 65 or older at the time of your retirement and elect not to enroll in medical coverage, you may not at any other time re-elect coverage under any of the Plan options.

General Provisions

Eligibility
If you are covered by the Plan immediately prior to your retirement, you are age 65 or older, and you have at least 10 years of employment, you may continue that coverage after retirement. You will need to elect a coverage option and category at the time of retirement. You may not defer your election to a later date; it is important that you give this decision careful consideration because this is the only time that you may enroll.

Eligible Dependents
As an eligible retiree, you may also choose to enroll your eligible dependents for coverage if they are enrolled for coverage immediately prior to your retirement. Eligible dependents include:

- your legally married spouse (The Plan does not allow dependent coverage for an ex-spouse even if a court mandates that you provide coverage) or eligible domestic partner; and
- your child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 26. This does not include a child for whom your parental rights have been legally terminated.

Coverage for an adult child, who attains age 26, will continue until the last day of the month in which his or her birthday occurs. Coverage for an adult child who reaches age 26 may be continued under the Plan if the adult child is unable to earn his own living because of a physical disability, mental illness or developmental disability. Coverage will be continued in accordance with "Dependents: Coverage Continuation under Special Circumstances."
If you and your spouse are both employees and/or retirees of Participating Employers, you may each be covered as a retiree, as an employee or as a dependent - but not in more than one capacity. In addition, only one of you is eligible to choose coverage for your dependent children.

**Important Note:** When you elect coverage for a dependent, you are certifying the eligibility of that individual as meeting the definition of a dependent as outlined in this Summary Plan Description. Knowingly enrolling or continuing coverage for an individual who does not meet the dependent eligibility requirements may result in corrective action up to, and including, termination of coverage.

**Domestic Partners**

An unmarried eligible retiree may enroll an unmarried same-sex or opposite-sex domestic partner as a dependent under the Plan. If you and your domestic partner meet the eligibility criteria set forth below and enroll in the Plan, benefit coverage generally is provided under the Plan as though your domestic partner were your spouse except where federal tax and other applicable laws and regulations prohibit doing so. To be eligible to enroll your domestic partner in the Plan, you and your domestic partner must meet the following criteria:

(a) have entered into a state-registered domestic partnership and provide proof that you (1) are registered as domestic partners in a state that formally recognizes domestic partners, (2) have entered into a civil union in a state that formally recognizes civil unions, or (3) are registered as reciprocal beneficiaries in a state that formally recognizes reciprocal beneficiaries to the extent that you are in a spouse-like relationship with and are not related to your reciprocal beneficiary; or

(b) if you do not meet the requirements of section (a), you and your domestic partner must:

1. share an exclusive, committed relationship together and intend to do so indefinitely;
2. have shared a common residence together for the past twelve (12) months;
3. be at least 18 years of age or older;
4. be jointly responsible for each other’s common welfare and financially interdependent;
5. not be related to a degree of closeness that would prohibit legal marriage in the state where you legally reside;
6. not be legally married to, or the domestic partner of, anyone else; and
7. satisfy such other criteria as the Company may require from time to time, including providing proof at the Company’s request that your domestic partnership meets the eligibility criteria set forth above.

If you and your eligible domestic partner are both employees and/or retirees of Participating Employers, you may each be covered as a retiree, as an employee or as a domestic partner - but not in more than one capacity. In addition, only one of you is eligible to choose coverage for your dependent children.

You may also cover your domestic partner’s children (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 26. Coverage for your domestic partner's adult child, who attains age 26, will continue until the last day of the month in which his or her birthday occurs. Coverage for an adult child of your domestic partner who reaches age 26 may be continued under this Plan if the adult child is unable to earn his own living because of a physical disability, mental illness or developmental disability. Coverage will be continued in accordance with the provisions of "Dependents: Coverage Continuation under Special Circumstances."

Please note that unless a domestic partner and his or her children are legal dependents of a retiree under Section 152 of the Internal Revenue Code, the retiree generally is taxed on the fair market value of the health coverage extended to the domestic partner and to any child of the domestic partner, reduced by any after-tax retiree contributions. This is called imputed income and is included in your gross taxable income and is subject to social security, federal, and other payroll withholding taxes.
Termination of Domestic Partnership
If your state-registered domestic partnership terminates or if you no longer meet all of the criteria of Domestic Partnership in this Summary Plan Description, you will need to submit a status change by calling Benefits Express at 1-800-758-4460 or online at Your Total Rewards. Upon termination of domestic partner coverage, coverage of the domestic partner’s children also terminates. Your former domestic partner may be eligible to continue coverage in accordance with the provisions of “COBRA-like Coverage for Domestic Partners.”

Important Note: When you elect coverage for a dependent, you are certifying the eligibility of that individual as meeting the definition of a dependent as outlined in this Summary Plan Description. Knowingly enrolling or continuing coverage for an individual who does not meet the dependent eligibility requirements may result in disciplinary action up to, and including, termination of coverage.

Making Changes after Retirement
Please note: As a retiree, there are restrictions on changes that can be made once you are enrolled. If at the time you retire your spouse or domestic partner declines coverage, he or she will not be allowed to elect coverage at any point in the future, unless one of the situations below occurs. After you retire, coverage can only be changed in the following situations:

- You may make a coverage election change to no coverage or you may drop covered dependents during the annual benefits enrollment period, usually held during the Fall of each year.

- You may change your coverage category if your spouse or domestic partner involuntarily loses coverage under his or her employer’s plan and has no other group coverage available. To cover a domestic partner, you must meet the eligibility requirements detailed on pages 6 and 7 and provide any proof the Company may require from time to time.

- You may change your coverage category if a covered dependent dies and there are no other covered dependents, or if, in accordance with the Health Insurance Portability and Affordability Act of 1996 (“HIPAA”) special enrollment rights, you acquire an eligible dependent through marriage, domestic partnership, birth, or adoption or placement for adoption of a child after your retirement. Once a dependent has dis-enrolled from coverage, they will not be allowed to re-enroll at a future date. Call Benefits Express at 1-800-758-4460 to request the change.

- If you, or any covered dependent enrolls in a Medicare Part D prescription drug program, you and all eligible dependents will automatically be moved to the Medical Only option and can never change to the Medical with Prescription Drug option in the future. The Medical Only option excludes prescription drug coverage.

- You may voluntarily drop coverage effective a date in the future any time during the plan year. Please note: This is not a COBRA qualifying event and once you elect to drop coverage, you cannot enroll in coverage at any time in the future.

COBRA Continuation Coverage
Employees who are enrolled in a Plan option and who retire, including those with less than 10 years of employment, will be eligible for COBRA coverage at retirement for up to 18 months, at a cost of 102% of the full price of coverage under the Plan. If you retire with 10 or more years of employment, although you are eligible for COBRA, if you elect COBRA instead of retiree coverage, you will not be eligible for retiree coverage at the end of the COBRA period. For more information, refer to the “Right To Continue Coverage” section.
Cost

Retirement on or after January 1, 2014
Effective January 1, 2014, the Company moved to a retiree cost-sharing arrangement with an annual fixed dollar Company contribution based on your years of eligible credited service. An active employee’s age and service as of December 31, 2013, is used to determine the age and service category to establish the contribution amount annual multiplier. Employees hired after December 31, 2013 will be in the less than 60 category. Eligible credited service for the purposes of determining your age and service category is based on the greater of your continuous years of service from your most recent hire date or years of vested service in the pension plan as of December 31, 20131. The annual contribution amount will be multiplied by your total number of years of eligible service at your retirement date (up to a maximum of 35 years). In the event you have a break in service, different rules apply as outlined on p. 13. For detailed information on cost of coverage, contact Benefits Express. Please note that rates and contribution levels for all retirees are subject to change at any time in the Company’s sole discretion. Payment for retiree coverage is made on an after-tax basis.

The following chart shows the 2017 contribution schedule for employees who qualify for retirement coverage and who are enrolled in the Plan immediately prior to their retirement date:

<table>
<thead>
<tr>
<th>Age + eligible credited service as of December 31, 2013</th>
<th>Health Coverage2 (Full-Time Employees)</th>
<th>Health Coverage2 (Part-Time Employees)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age 65 or Older (Medicare Eligible)</td>
<td>Age 65 or Older (Medicare Eligible)</td>
<td></td>
</tr>
<tr>
<td>85 or more</td>
<td>$34.46</td>
<td>$17.23</td>
</tr>
<tr>
<td>80 – 84</td>
<td>$32.31</td>
<td>$16.15</td>
</tr>
<tr>
<td>75 – 79</td>
<td>$30.16</td>
<td>$15.08</td>
</tr>
<tr>
<td>70 – 74</td>
<td>$28.00</td>
<td>$14.00</td>
</tr>
<tr>
<td>65 – 69</td>
<td>$25.85</td>
<td>$12.93</td>
</tr>
<tr>
<td>60 – 64</td>
<td>$23.69</td>
<td>$11.85</td>
</tr>
<tr>
<td>Less than 60</td>
<td>$21.54</td>
<td>$10.77</td>
</tr>
</tbody>
</table>

1Pension credited service through December 31, 2013, will be based on the applicable vesting schedule in place as of your initial termination date (i.e., 5 or 10 years).

2The Company contribution amount will increase by 2.5% on an annual basis to help retirees manage health care cost inflation.

Example - Post-65 Health Care Costs: As of December 31, 2013, an employee was age 63 with 26 years of eligible credited service. If the employee retires in December 2017 at age 66, cost-sharing would be determined as follows for the Medical with Prescription Drug Option:
In 1996, the Company announced it was introducing cost-sharing to all retirees enrolled in the Plan. The cost-sharing was designed to begin at the later of the point in time where costs reached 125% of 1996 costs or the year 2000. In the year 2000, the cost-sharing arrangement was implemented for those retirees age 65 and older and the monthly cap was set. To establish the cap, the 1996 average monthly cost was multiplied by 125%. The starting point for Liberty’s contribution is 100% of the full monthly cost of coverage up to the cap plus 50% of the cost above the cap. This amount in then adjusted by the Company’s cost-sharing percentage based on your years of eligible service at retirement.

The following chart is the current percentage contribution schedule (before cap) for employees who qualify for retirement coverage, who retired on or after January 1, 1993 and before December 31, 2013, and who are age 65 or older and enroll in the Medical with Prescription Drug option:

<table>
<thead>
<tr>
<th>Step 1: Determine Age + Eligible Credited Service Cost-Share Tier as of 12/31/2013</th>
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<tr>
<td>63 (Age) + 26 (eligible credited service) = 89 [85 or more tier]</td>
</tr>
</tbody>
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<th>Step 2: Determine Eligible Credited Service as of Date of Termination</th>
</tr>
</thead>
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<tr>
<td>11/30/2017 (date of termination) - 11/30/1987 (date of hire) = 30 years</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Step 3: Calculate Annual Company Contribution Amount¹</th>
</tr>
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<tbody>
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<td>$34.46 (85 or more tier) X 30 (eligible credited service from Step 2) = $1,033.80</td>
</tr>
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<table>
<thead>
<tr>
<th>Step 4: Calculate Annual Retiree Contribution Amount</th>
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<tr>
<td>2017 Annual Health Care Cost (Retiree Only)²</td>
</tr>
<tr>
<td>- Annual Company Contribution Amount</td>
</tr>
<tr>
<td>Annual Retiree Cost</td>
</tr>
<tr>
<td>Monthly Retiree Cost</td>
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¹Includes the 2.5% annual increase in the Company contribution
²Annual Health Care Cost shown is net of the annual EGWP subsidy
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<th>Years of Service at Retirement*</th>
<th>Percent of the Price Paid by Retiree (Formerly Full-Time)</th>
<th>Percent of the Price Paid by Retiree (Formerly Part-Time)</th>
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<tr>
<td>10 or more but less than 20</td>
<td>60%</td>
<td>80%</td>
</tr>
<tr>
<td>20 or more but less than 25</td>
<td>50%</td>
<td>75%</td>
</tr>
<tr>
<td>25 or more but less than 30</td>
<td>40%</td>
<td>70%</td>
</tr>
<tr>
<td>30 or more but less than 35</td>
<td>30%</td>
<td>65%</td>
</tr>
<tr>
<td>35 or more years</td>
<td>20%</td>
<td>60%</td>
</tr>
</tbody>
</table>

*Note: Generally only continuous service with your employer during the period your employer is a Participating Employer counts for determining eligibility and cost-sharing for post-retirement Medical coverage. In some cases, however, service with your employer prior to its becoming a Participating Employer or service with a previous employer, may count towards eligibility and cost-sharing:

- Former CIGNA Bond Services employees who were employed as of January 24, 1994, receive credit for prior employment service with ICNA for purposes of eligibility and cost-sharing.

- Former CUMIS General Insurance Co. and CUNA Mutual General Agency of Texas employees who transferred to a Participating Employer in conjunction with the acquisition of CUMIS General on July 1, 1998, receive credit for prior employment service with CUNA Mutual Insurance Co. for purposes of eligibility and cost-sharing.

- Golden Eagle Insurance Corporation employees who were employed as of October 1, 1997, receive credit for prior employment service with Golden Eagle Insurance Co. for purposes of eligibility only.

- Liberty Real Estate Management, Inc. employees who were employed on January 1, 1997, receive credit for prior employment service with Liberty Real Estate Group, Inc. and Liberty Sanibel II Limited Partnership for purposes of eligibility and cost-sharing.

- Wausau Service Corporation and former Nationwide Trial Division employees who were employed as of the acquisition date of December 31, 1998, receive credit for prior employment service with Wausau Service Corporation and Nationwide Trial Division for purposes of eligibility and cost-sharing.

- Atlantic Health Group employees who were employed as of March 31, 1997, receive credit for prior employment service with New England Health Group from the later of January 2, 1996, or the employee’s date of hire for purposes of eligibility and cost-sharing.

- ACE employees who were employed as of January 1, 2000, receive credit for prior continuous service from their last full-time hire date with CIGNA (if they transferred from CIGNA to ACE on July 2, 1999) or from their last full-time hire date with ACE (if hired by ACE after July 2, 1999) for purposes of eligibility and cost-sharing.

- RAM employees who were former employees of The Netherlands Insurance Company (“TNIC”) who lost or retained post-retirement coverage under the TNIC welfare benefit plans as of December 31, 1998, and who are employed by TNIC on December 31, 2000, will receive prior service credit for purposes of eligibility and cost-sharing.
  - RAM employees who were not former employees of TNIC referenced above are granted past service credit towards eligibility, but not cost-sharing, provided, however, that such employees who have less than 10 years of service for cost-sharing but at least 10 years of service for eligibility will be eligible for the minimum Company contribution to the cost of the post-retirement plan.

- RAM and Liberty Mutual employees who were former employees of OneBeacon Insurance Company on December 31, 2001 and who are employed by Participating Employers on January 1, 2002, receive credit for prior employment service with OneBeacon companies for purposes of eligibility and cost-sharing.
• Former employees of Merchants Holding Corporation who transferred and became employees of The Netherlands Insurance Company on April 1, 2002, receive credit for prior employment service with Merchants Holding Corporation for eligibility purposes only.

• Cascade Disability Management, Inc. (“Cascade”) employees employed with Cascade as of January 1, 2003, receive credit for prior employment service with Cascade for eligibility purposes only.

• Former employees of Liberty Financial Companies, Inc. (“LFC”) who are employed by Participating Employers on or after January 1, 2003, receive credit for prior employment service with LFC for eligibility purposes only.

• Former employees of Prudential Commercial Insurance Company, Inc., Prudential General Insurance Company, and Prudential Property and Casualty Insurance Company (collectively referred to as “Prudential”) who transferred to Participating Employers on November 1, 2003, receive credit for prior employment service with Prudential, for eligibility purposes only.

• Liberty Northwest employees employed with Liberty Northwest as of January 1, 2004, receive credit for prior employment service with Liberty Northwest for purposes of eligibility and cost-sharing.

• Former Ohio Casualty Corporation (OCAS) employees who were employed by a Participating Employer as of January 1, 2008 and retire after December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Employees with 25 years of continuous eligible service as of July 1, 2004:</th>
<th>Employees with less than 25 years of continuous eligible service as of July 1, 2004 and more than 10 years of total service:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Younger than Age 65</td>
<td>Cost sharing based on actual years of eligible credited service with Ohio Casualty and Liberty Mutual (up to a maximum of 35 years).</td>
</tr>
<tr>
<td>Age 65 or Older</td>
<td>Company contribution category: 75 to 79 Years of eligible credited service: 25</td>
</tr>
</tbody>
</table>
• Former employees of Ohio Casualty Corporation (OCAS) who transitioned to Participating Employers on January 1, 2008, and retired before December 31, 2013 will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Employees with 25 years of continuous eligible service as of July 1, 2004:</th>
<th>Employees with less than 25 years of continuous eligible service as of July 1, 2004 and more than 10 years of total service:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Younger than Age 65</strong></td>
<td>Cost sharing based on actual years of eligible credited service with Ohio Casualty and Liberty Mutual (up to a maximum of 35 years).</td>
</tr>
<tr>
<td>Age 65 or Older</td>
<td>Cost sharing based on 25-29 years of service category.</td>
</tr>
<tr>
<td></td>
<td>Cost sharing based on 10-19 years of service category.</td>
</tr>
</tbody>
</table>

• Former employees of Safeco Corporation and subsidiaries who transitioned to Participating Employers on January 1, 2009, will receive credit for prior employment service with Safeco for eligibility purposes only.

• Former grandfathered employees of Safeco Corporation and subsidiaries transitioning to Participating Employers on January 1, 2009 who retire after December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Grandfathered Age and Service Points as of 12/31/2004</th>
<th>Younger than Age 65</th>
<th>Age 65 or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>87 or more</strong></td>
<td>Company contribution category: 85 Credited service for multiplier(^1): 35</td>
<td>Company contribution category: &lt;60 Credited service for multiplier(^1): 10</td>
</tr>
<tr>
<td><strong>82 through 86</strong></td>
<td>Company contribution category: 85 Credited service for multiplier(^1): 32</td>
<td>Company contribution category: &lt;60 Credited service for multiplier(^1): 10</td>
</tr>
<tr>
<td><strong>78 through 81</strong></td>
<td>Company contribution category: 80 to 84 Credited service for multiplier(^1): 22</td>
<td>Company contribution category: &lt;60 Credited service for multiplier(^1): 10</td>
</tr>
<tr>
<td><strong>75 through 77</strong></td>
<td>Company contribution category: 70 to 74 Credited service for multiplier(^1): 12</td>
<td>Company contribution category: &lt;60 Credited service for multiplier(^1): 10</td>
</tr>
</tbody>
</table>

\(^1\) In the event that eligible credited service from January 1, 2009 forward is greater, the credited service can increase up to a maximum of 35 years of credited service.
• Former grandfathered employees of Safeco Corporation and subsidiaries who transitioned to Participating Employers on January 1, 2009, who retired before December 31, 2013, will receive credit for purposes of eligibility and cost-sharing based on the following:

<table>
<thead>
<tr>
<th>Grandfathered Age and Service Points as of 12/31/2004</th>
<th>Younger than Age 65</th>
<th>Age 65 or Older</th>
</tr>
</thead>
<tbody>
<tr>
<td>87 or more</td>
<td>Cost-sharing based on 35+ years of service category.</td>
<td>Cost-sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>82 through 86</td>
<td>Cost-sharing based on 30-34 years of service category.</td>
<td>Cost-sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>78 through 81</td>
<td>Cost-sharing based on 20-24 years if service category.</td>
<td>Cost-sharing based on 10-19 years of service category.</td>
</tr>
<tr>
<td>75 through 77</td>
<td>Cost-sharing based on 10-14 years of service category.</td>
<td>Cost-sharing based on 10-19 years of service category.</td>
</tr>
</tbody>
</table>

Note: Eligible participants who were retired at the time of the acquisition and transitioned to the Company’s plans may have a different cost-sharing arrangement based on the agreement in place at the time of acquisition. Price tags and contribution levels are subject to change at the Company’s discretion.

**Break in Service**

For purposes of determining eligible credited service for post-retirement health coverage, a termination of employment prior to retirement eligibility impacts whether or not you receive any service credit under the plan as outlined below.

Eligible Credited Service with a Participating Employer will be maintained if there is a break in service of less than 12 months.

1. **Employees rehired with a one-year or less than break in service from date of termination:**

<table>
<thead>
<tr>
<th>Health &amp; Welfare Age &amp; Service Tier at Retirement</th>
<th>Service for Determining Subsidy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Who were employed in 2013</td>
<td>Elongible credited service prior to termination + Continuous service</td>
</tr>
<tr>
<td>Age + Service as of December 31, 2013.</td>
<td></td>
</tr>
<tr>
<td>Who were not employed in 2013</td>
<td>Eligible credited service prior to termination + Continuous service</td>
</tr>
<tr>
<td>Less than 60</td>
<td></td>
</tr>
<tr>
<td>Retiree Rehire (whether or not enrolled in retiree Health &amp; Welfare at initial retirement)</td>
<td>Eligible credited service prior to termination + Continuous service</td>
</tr>
<tr>
<td>Age + Svc as of December 31, 2013 -or- Determined based on Age + Eligible credited service prior to break</td>
<td></td>
</tr>
</tbody>
</table>

*Up to a maximum of 35 years of eligible credited service.
**Note:** Employees with multiple consecutive service breaks of 12 months or less will have an adjusted continuous service date calculated.

Eligible credited service with a participating employer will change if the break in service exceeds one year, based on service at the time of the termination.

2. **Employees rehired with a one-year or greater than break in service from date of termination:**

<table>
<thead>
<tr>
<th>Health &amp; Welfare Age &amp; Service Tier at Retirement</th>
<th>Additional Service Required</th>
<th>Service for Determining Subsidy*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employee with at least 5 years of eligible credited service prior to break (including Acquisition Groups)</td>
<td>Less than 60 Points</td>
<td>At least 5 years of Continuous service</td>
</tr>
<tr>
<td>Employee without at least 5 years of eligible credited service prior to break (including Acquisition Groups)</td>
<td>Less than 60 Points</td>
<td>At least 5 years of Continuous service</td>
</tr>
<tr>
<td>Retiree Rehire enrolled in retiree Health &amp; Welfare</td>
<td>Age + Service as of December 31, 2013 -or- Determined based on Age + eligible credited service prior to break in service</td>
<td>None</td>
</tr>
<tr>
<td>Retiree Rehire not enrolled in retiree Health &amp; Welfare</td>
<td>Less than 60 Points</td>
<td>At least 5 years of continuous service</td>
</tr>
</tbody>
</table>

*Up to a maximum of 35 years of eligible credited service.

**Note:** If you are a regular full-time employee, a one-year break in service results with respect to each 12 consecutive month period after your "service termination date" (as defined in the Plan; generally, the date your employment ends) in which you are not credited with an hour of service. If you are a part-time employee or temporary full-time employee, a one-year break in service occurs for any calendar year in which you are credited with 500 or fewer hours of service.

3. **Employees on a leave of absence due to a Long-Term Disability** received age and service credit while on long-term disability only through December 31, 2013. No future service credit will apply to employees while on a leave of absence due to a long-term disability after December 31, 2013.

**Identification Cards**

If you participate in the Medical with Prescription Drug option, you will receive a health care identification card directly from UnitedHealthcare, the claims administrator, shortly after the coverage becomes effective.
Replacement cards necessary because of a name change will be processed by the appropriate claims administrator once notification of the change is received. Additional cards for other family members or replacement cards necessary because the originally issued card has been lost or damaged should be requested by contacting your claims administrator's Member Services group.

If you are a participant in the Medical with Prescription Drug option, you will also receive prescription drug identification cards for the SilverScript prescription drug program described later in this Summary Plan Description. If you need replacement or additional prescription drug identification cards, contact SilverScript at 1-888-644-0334 or on the internet at www.caremark.com

Dependents: Coverage Continuation under Special Circumstances

**Disabled Dependent Children**
A covered retiree may continue coverage for certain dependent children who reach the age at which coverage would otherwise cease if the following conditions are met. First, the retiree must provide proof that the child is unable to earn his own living for reasons of physical handicap or mental illness. You must have dependent coverage for the child under the Plan on the date he/she reaches age 26. Medical proof of the disability must be received by the appropriate claims administrator within 30 days after the last day of the month he/she reaches age 26. Second, after reviewing the medical proof submitted, the appropriate claims administrator must approve a child’s status as mentally or physically disabled in order for coverage to continue.

The covered retiree’s or domestic partner’s child will be considered a covered dependent so long as the covered retiree submits due proof upon request by the claims administrator that the child remains physically or mentally unable to earn his own living.

The Company, at its own expense, may have a physician of its choice examine the child during the time his coverage is continued. An exam will not be required more than once a year.

A covered retiree’s coverage for such child will end according to the provisions under Termination of Coverage or on the earliest of:

- the date the child is able to earn his or her own living;
- failure to provide due proof that the child is unable to earn his or her own living; or
- failure of the child to submit to an exam by a physician.

**Dependents of Deceased Retirees**
If a retiree’s spouse or domestic partner and dependent children are enrolled in coverage at the time of the retiree’s death, the spouse or domestic partner and dependent children of the deceased retiree may continue their coverage upon payment of the applicable cost. The coverage can continue as long as the spouse remains unmarried and does not enter into a new domestic partner relationship or the domestic partner remains unmarried and does not enter into a new domestic partner relationship, and the children are dependents as defined in the Plan. Coverage terminates automatically on the date of the surviving spouse’s remarriage, entry into a new domestic partnership or the domestic partner’s marriage or entry into a new domestic partnership. See “Dependents of Deceased Retirees” in the “Right to Continue Coverage” section.

Please note that once a surviving spouse or domestic partner attains age 65 or becomes eligible for Medicare, the survivor and any dependents that he or she is covering under the Plan will continue their coverage in the Retiree Health Plan.
Benefits for Disabled Dependents of a Retiree
If your covered dependent becomes eligible for Medicare for any reason other than reaching age 65 (for example, if a permanent disability results in Medicare eligibility), you must contact Benefits Express to inform them of your dependent’s Medicare eligibility and elect coverage for them under the Medical with Prescription Drug or the Medical Only options. If you do not report the change in Medicare status to Benefits Express and incur claims that are paid primarily by the Plan, you may be responsible for repaying any amounts that should have been paid by Medicare, rather than the Plan.

Please note: Retirees age 65 and older and Medicare eligible dependents can enroll in either the Medical with Prescription Drug or the Medical Only option. If a retiree or covered dependent elects the Medical Only option, this election applies to all participants upon reaching Medicare eligibility with no opportunity to elect the Medical with Prescription Drug option in the future.

How the Medical with Prescription Drug Option Works
As described previously, the Medical with Prescription Drug option has an annual deductible and family out-of-pocket maximum. No benefit is payable until the deductible amount of Covered Health Care Expenses incurred by any individual in any calendar year is met except for certain preventive care benefits which are covered at 100% with no deductible. Please note that if you have Medicare coverage, Medicare is considered your primary coverage and obtaining prior authorization before receiving health care does not apply. Please refer to the “Medicare” and “Non-Duplication of Benefits” sections later in this Summary Plan Description for details. Note: The annual deductible does not apply to the SilverScript prescription drug program, which is not subject to an annual deductible, nor do coinsurance amounts paid for prescription drugs apply toward the annual deductible or out-of-pocket maximums.

You pay a $200 charge per visit for use of an emergency room. The $200 charge is paid before the deductible or any coinsurance and does not count towards the annual deductible or out-of-pocket maximum. The $200 charge is not waived if you are admitted to the hospital. You continue to pay your deductible and 80% coinsurance of the R&C amount.

Covered Health Care Expenses used toward the deductible during the last three months of a calendar year may be used toward the deductible for the following year, as long as no expense was paid in the prior calendar year. For example, the first expense that a covered person incurs during the year occurs in December and amounts to $275.00. If that expense is not paid until January or later, and the individual continues to enroll in the Medical with Prescription Drug option in the next year, and incurs no additional expenses during December, the $275.00 will be applied to satisfy the following year's deductible and, thus, the individual will only need to incur $25.00 in covered charges to satisfy the following year's deductible.

Please refer to the “Covered Health Care Expenses” and “Exclusions” sections for detailed information on coverage and limitations and exclusions under the Plan.
Covered Medical Expense Coinsurance Percentages and Out-of-Pocket Maximums

The Plan will pay a portion of the Covered Health Care Expenses incurred by each covered individual in each calendar year, subject to:

- an annual deductible; and
- the Plan’s limitations, exclusions, and exceptions.

In the Medical with Prescription Drug option, you pay an annual deductible of $300/individual, $600/retiree and spouse or retiree and domestic partner, and $900/family. After you meet the annual deductible, Covered Health Care Expenses are paid at 80% of the Reasonable and Customary amount, with special limits applying to certain charges.

To protect you against unusually high expenses, the Plan also includes annual out-of-pocket maximums. If your out-of-pocket expenses (that is, the deductible plus the coinsurance) reach the maximum in any given year, the Plan will pay 100% of R&C charges of any remaining covered expenses for that year. Maximum Covered Health Care Expenses payable by a retiree age 65 or older are $1,500/individual, $3,000/individual and spouse or retiree domestic partner, and $4,500/family. Please see the “Non-Duplication of Benefits” section for an example.

**Note:** The coinsurance percentage applies to treatment of mental and behavioral disorders or substance abuse in all instances. Coinsurance for prescription drugs purchased through SilverScript also applies in all instances. Prescription drug coinsurance amounts do not apply toward the Plan’s annual deductible or annual out-of-pocket maximum. The $200 charge per visit for the use of an emergency room is paid before the deductible or any coinsurance and does not count towards the annual deductible or out-of-pocket maximum. The $200 charge is not waived if you are admitted to the hospital.

**Treatment of Mental and Behavioral Disorders While Not Confined in a Hospital**

**Treatment for Substance Abuse (Chemical Dependency) While Not Confined in a Hospital**

The Plan will pay 80% of Covered Health Care Expenses after the annual deductible for benefits under the Medical with Prescription Drug option.

Covered Health Care Expenses for professional charges for Treatment of Mental and Behavioral Disorders and Substance Abuse While Not Confined in a Hospital are limited to charges made by a licensed psychiatrist, licensed psychologist or licensed clinical social worker. Charges made by certified addiction counselors are also Covered Health Care Expenses, but only if the treatment is rendered in connection with an accredited outpatient substance abuse treatment program. Charges made by marriage and family therapists are not Covered Health Care Expenses, unless there is a valid behavioral health diagnosis associated with the visit.

**Treatment of Mental and Behavioral Disorders While Confined in a Hospital**

**Treatment for Substance Abuse (Chemical Dependency) While Confined in a Hospital**

The Plan will pay 80% of Covered Health Care Expenses after the annual deductible for benefits under the Medical with Prescription Drug option, for the treatment of mental and behavioral disorders and substance abuse (including inpatient detoxification treatment) while hospital-confined.
Other Hospital Charges
The Plan will pay 80% of Covered Health Care Expenses after the annual deductible for benefits under the Medical with Prescription Drug option, for hospital charges listed under subparagraph (1) under Covered Health Care Expenses definition.

Second Opinion
The Plan will pay 80% of Covered Health Care Expenses after the annual deductible is met for benefits under the Medical with Prescription Drug option, for a second opinion.

Pre-Admission Testing
The Plan will pay 80% of Covered Health Care Expenses after the annual deductible is met for benefits under the Medical with Prescription Drug option, for charges for pre-admission testing.

Other Health Care Treatment
After the annual deductible is met, the Plan will pay 80% of Covered Health Care Expenses for benefits under the Medical with Prescription Drug option.

Pharmacy Benefit
See the “Prescription Drug Program” section for an explanation of the prescription drug program for participants in the Medical with Prescription Drug option.

Increases and Decreases in Amounts of Coverage
Any increase in or addition of benefits will take effect on the effective date of the increase or addition. Any such change applies only to Covered Health Care Expenses incurred on or after the effective date of the change. Any decrease in or deletion of benefits will take effect on the date of the decrease or deletion. Any such change applies only to Covered Health Care Expenses incurred on or after the effective date of the change.

Emergency Situations
In life-threatening emergency situations (e.g., severe chest pains, prolonged bleeding, broken bones, etc.) seek medical care immediately. For Medical with Prescription Drug option members, you pay a $200 charge per visit for use of an emergency room. The $200 charge is paid before the deductible or any coinsurance and does not count towards the annual deductible or out-of-pocket maximum. If you are admitted to the hospital, you pay the $200 charge and your Covered Health Care Expenses are paid at 80% of the R&C amount after the deductible is met.

Definitions
A masculine personal pronoun includes the feminine where the context requires.

"Accidental injury" or "injury" means bodily injury caused by an accident. This includes related conditions and recurrent symptoms of such injury.

“Active employee” means any full-time or part-time employee of a Participating Employer.
"Ambulatory surgical center" (or free-standing emergency center) means a facility that:

(a) is established, equipped and operated mainly to perform surgical procedures;
(b) is operated under the supervision of a staff of physicians and provides the full-time services of at least one RN;
(c) is licensed by the jurisdiction in which it is located;
(d) has at least two operating rooms and at least one post-anesthesia recovery room;
(e) has a written transfer agreement with one or more hospitals and does not provide its own place for patients to stay overnight;
(f) is not an establishment which is operated by one or more physicians solely for their own patients; and
(g) maintains medical records for each patient.

"Annual deductible" means the amount of money you pay each plan year before the Plan begins to pay benefits for eligible expenses.

"Birthing center" means a facility licensed as such according to the statute in the state where the facility is located.

"Brand name drug" means a prescription drug that is protected by a patent and is marketed under a specific name.

"Calendar year" means the period starting January 1 of any year and continuing through December 31 of that same year.

"Claims administrator" means the party designated by the Plan Administrator to administer claims. Your claims administrator is determined by the coverage option you select. UnitedHealthcare is the claims administrator for the Medical with Prescription Drug option. The claims administrator for the Prescription Drug Program is SilverScript Insurance Company, administered by CVS/caremark.

"Coinsurance" means the share you have to pay of your Covered Health Care Expenses.

"Cosmetic surgery" means surgery performed to reshape normal structure of the body in order to improve the patient’s appearance and self-esteem.

"Covered dental injury" means an injury caused by a sudden and violent external force. The injury must be unexpected and unavoidable. A chewing injury is not a covered dental injury.

"Covered dependent" means a dependent whose coverage under the Plan is in effect. It does not include a dependent whose coverage under the Plan has ended.

"Covered person" means a covered employee, covered retiree, or a covered dependent.

"Covered retiree" means a covered retiree whose coverage under the Plan is in effect. It does not include a retiree whose coverage under the Plan has ended.

"Custodial care" means a level of routine maintenance or supportive care, whether provided in the home or in an institution or other facility, which need not be provided by skilled professional medical personnel and will include, but not be limited to, care designed to assist the covered person in the activities of daily living.
"Dependent" means: (a) a retiree’s spouse; and (b) a retiree’s child (including any stepchild, foster child, legally adopted child or a child for whom a court order of custody or guardianship has been obtained) under age 26. This does not include a child for whom your parental rights have been legally terminated.

"Dependent" does not include a person who is: (a) covered under this Plan as a retiree; or (b) a legally divorced spouse.

Coverage for an adult child who reaches age 26 may be continued under this Plan if the adult child is unable to earn his own living because of a physical handicap, mental illness or developmental disability.

Coverage will be continued in accordance with "Dependents: Coverage Continuation Under Special Circumstances."

An unmarried retiree may cover as a dependent under the Plan a domestic partner provided the retiree and the domestic partner meet all the eligibility criteria and requirements detailed on pages 6 and 7. 

"Dependent coverage" means coverage of a covered retiree with respect to his dependents.

"Durable medical equipment" means equipment which:

(a) can withstand repeated use;

(b) is primarily and customarily used to serve a medical purpose;

(c) is generally not useful to a person in the absence of injury or sickness;

(d) is appropriate for use in the home;

(e) is not primarily and customarily for the convenience of the covered person; and

"Eligible dependent" means a dependent of a retiree who is eligible for coverage.

"Emergency medical condition" means the sudden onset of an injury or acute illness that has the capability to cause severe pain, loss of consciousness, excessive bleeding or which becomes a threat to life or limb if medical treatment is not rendered promptly. Examples include severe chest pains, prolonged bleeding, seizures, severe allergic reaction, poisoning, loss of consciousness, and broken bones.

"Employee" means an employee of a Participating Employer who is eligible for coverage.

"Generic drug" means a drug that has the same active ingredients as the brand name drug that no longer is protected by a patent. FDA-approved generic drugs are therapeutically equivalent to the original and usually are less expensive.

"Home health aide" means a certified or trained professional who provides services through a home health care agency which:

(a) are not required to be performed by an RN, LPN or LVN;

(b) primarily aid the covered person in performing the normal activities of daily living while recovering from an injury or sickness; and

(c) are described under the home health care plan.
"Home health care agency" means an agency or organization that:

(a) is licensed, if required, by the appropriate licensing body to provide home health services and supplies;
(b) is primarily engaged in nursing and other therapeutic services; and,
(c) has its policies set up by professionals associated with the agency.

"Home health care plan" means a program for continued health care and treatment in the covered person's home. It must either (a) follow within 24 hours of and be for the same or related cause(s) as a period of hospital or skilled nursing facility confinement; or (b) be in lieu of a hospital or skilled nursing facility confinement. It must be set up, approved in writing and renewed every 60 days by a physician. Such physician must certify that the proper treatment would require confinement as an inpatient in a hospital or skilled nursing facility if the services and supplies were not provided under a home health care plan. He must also examine the covered person at least once a month.

"Hospice" means a facility or program providing a coordinated program of home and inpatient care which treats terminally ill patients. The program provides care to meet the special needs of the patient during the final stages of a terminal illness. Care is provided by a team made up of trained medical personnel, counselors and volunteers. The team acts under an independent hospice administration, helping the patient to cope with physical, psychological, and social stresses. The hospice administration must meet the standards of the national Hospice Organization and any licensing requirements.

"Hospice benefit period" means a period that begins on the date the attending physician certifies that the covered person is a terminally ill patient who has less than six months to live.

"Hospice care expenses" are R&C charges made by a hospice for the following services or supplies:

(a) charges for inpatient care;
(b) charges for drugs and medicines;
(c) charges for part-time nursing by an RN, LPN or LVN;
(d) charges for physical and respiratory therapy in the home;
(e) charges for the use of medical equipment;
(f) charges for visits by licensed or trained social workers, psychologists, counselors, or home health aides;
(g) charges for respite care for up to 5 days in any 30-day period.

"Hospital" means a lawfully operating institution engaged mainly in providing treatment of sick or injured persons. The treatment must be by or under the supervision of a physician. The institution must have 24-hour nursing services by or under the supervision of RNs. It must have organized facilities on the premises for: (a) diagnosis; and (b) major surgery, unless it is a hospital dealing mainly in the treatment of mental disease, alcoholism, drug addiction or TB. "Hospital" does not include: nursing or convalescent homes; half-way houses for recovering alcoholics or drug addicts; extended care facilities; homes for the aged or places for custodial care; and sanitariums maintained or accredited by the Christian Science Church.

If a hospital does not have semi-private rooms, "semi-private room rate" means 80% of a hospital's daily charge for its lowest rate private room.

"Immediate family" means a covered person's spouse, domestic partner, child, domestic partner's child, brother, sister, parent or in-laws.
"Medically necessary" means a service or supply which the Plan determines is: (a) required for the treatment or management of an injury or sickness; (b) commonly and customarily recognized by physicians as appropriate in the active therapeutic treatment or management of the injury or sickness (as determined by the AMA or other nationally recognized medical boards); (c) other than educational or experimental; (d) not primarily for the comfort or convenience of the physician or covered person; (e) given in the most cost-efficient setting consistent with maintaining high quality care; and (f) for other than custodial care.

With respect to confinement in a hospital, "medically necessary" further means that the medical condition requires confinement and that safe and effective treatment cannot be provided as an outpatient.

"Non-preferred prescription" means a prescribed drug that is not on the SilverScript “formulary” (preferred list) of brand name drugs.

"Personal coverage" means coverage of a covered retiree with respect to himself.

"Physician" means only (a) a medical practitioner who is legally qualified to prescribe and administer all drugs and to perform all surgical procedures; or (b) a licensed dentist practicing within the terms of his license; or (c) a psychologist practicing in conformity with applicable state law; or (d) any other licensed practitioner of the healing arts in a category specifically favored under the health insurance laws of the state where the service for which claim is made is performed, practicing within the terms of his license.

"Pre-admission testing" means necessary diagnostic x-rays or laboratory tests as an outpatient under a pre-admission testing program administered by a hospital. Under such a program, the tests must be: (a) ordered by the physician who directs confinement; (b) made within seven days immediately before treatment and at the same hospital where treatment will be rendered and (c) accepted by the hospital in place of the same tests that would normally be made after confinement. Benefits are payable for pre-admission tests only if benefits would have been payable for the same test should they have been performed while confined as an in-patient.

"Preferred brand name prescription" means a prescribed drug that is included in the SilverScript “preferred” or formulary list of brand name drugs. SilverScript selects drugs based on their safety, clinical efficacy, and cost-effectiveness to the Plan.

"Pregnancy" includes miscarriage, abortion, childbirth or any complications thereof.

"Reasonable and customary (R&C) charge" means the lesser of: (a) the charge that a provider most often charges patients for the service or procedure; or (b) the customary charge for the service or procedure. Such customary charge will be determined from within the range of charges made for the service or procedure by most providers in the general geographic area where the provider maintains his usual place of business. The R&C charge will not exceed the 80th percentile of the HIAA (Health Insurance Association of America) prevailing fee schedules (or the schedule used by the claims administrator that most closely approximates the HIAA fee schedules).

"Rehabilitation facility" means an institution whose primary purpose is to provide restorative therapy to disabled persons. Such facility must be licensed as such in the state in which it operates or be certified by CARF (Commission on Accreditation of Rehabilitation Facilities). "Rehabilitation Facility" does not include places for custodial care or places for confinement of drug addicts or alcoholics.

"Respite care" means care provided to give temporary relief to the family or other care givers in emergencies and from the daily demands for caring for a terminally ill covered person.

"Retiree" means one who is so classified by the Participating Employer.
"Second opinion" means an opinion of a physician based on his examination of a person to evaluate the need for an elective procedure. The person must be examined in person by the physician giving the second opinion. "Second Opinion" does not include an opinion given: (a) by the physician who gives the treatment; (b) while the person is hospital-confined as an inpatient; (c) for dental surgery; (d) for childbirth or elective abortion; or (e) for any procedure not covered under the Plan. A second opinion will include a third opinion if the second opinion does not confirm the need for treatment.

"Sickness" means disease or illness including related conditions and recurrent symptoms of the sickness. Sickness also includes pregnancy.

"Skilled nursing facility" means a lawfully operating institution engaged mainly in providing treatment for people convalescing from injury or sickness. It must have:

   (a) organized facilities for medical services; and
   (b) 24-hour nursing service by Registered Nurses; and
   (c) a capacity of six or more beds; and
   (d) daily medical records for each patient; and
   (e) a physician available at all times.

If a skilled nursing facility does not have semi-private rooms, "semi-private room rate" means 80% of that facility's daily charge for its lowest rate private room.

"Skilled nursing facility" does not include: rest homes, homes for the aged, places for custodial care, or places for confinement of drug addicts or alcoholics.

"Sound teeth" are teeth that: (1) are fully restored to function; (2) do not have any decay; (3) are not more susceptible to injury than virgin teeth; (4) do not have significant periodontal disease or (5) teeth must be in good repair and firmly attached to the jaw at the time of injury.

“Virtual health care visits” allow you to see and talk to a provider, for non-emergencies, from your mobile device or computer.

Covered Health Care Expenses

Covered Health Care Expenses incurred for services and supplies:

<table>
<thead>
<tr>
<th>Covered Health Care Expenses incurred for services and supplies:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• must be medically necessary;</td>
</tr>
<tr>
<td>• must be prescribed or ordered by the attending physician;</td>
</tr>
<tr>
<td>• will not include amounts in excess of the reasonable and</td>
</tr>
<tr>
<td>customary charge.</td>
</tr>
</tbody>
</table>

The date the service is performed or the supply is purchased is the date the covered medical expense is incurred.
The Covered Health Care Expenses are:

(1) Hospital charges for:
   (a) room and board but not in excess of the hospital's average rate for semi-private accommodations;
   (b) an intensive care unit;
   (c) services and supplies during hospital confinement as an inpatient;
   (d) outpatient services for surgery;
   (e) outpatient services for treatment of an emergency medical condition;
   (f) outpatient services for pre-admission testing;
   (g) outpatient services for chemotherapy, radiation therapy and dialysis.

(2) Charges made by an ambulatory surgical center for services in connection with outpatient surgery.

(3) Charges made by a birthing center for treatment in connection with pregnancy.

(4) Charges made by a skilled nursing facility for treatment rendered while confined:
   (a) in lieu of a hospital confinement; or
   (b) within 24 hours following a hospital confinement and for the same or related cause(s) as such hospital confinement.

Room and board charges in excess of the skilled nursing facility's average rate for semi-private accommodations and any charges for days of confinement in excess of 100 in a calendar year are not Covered Health Care Expenses.

(5) Charges made by a rehabilitation facility when confinement in the facility follows within 24 hours of and is for the same or related cause(s) as a period of hospital or skilled nursing facility confinement.

(6) Charges made by a home health care agency for treatment rendered in a covered person's home pursuant to a home health care plan. Covered Health Care Expenses for home health care are limited to the following:
   (a) part-time or intermittent nursing care by or under the supervision of an RN, LPN or LVN;
   (b) part-time home health aide services that consist primarily of caring for the patient;
   (c) services provided by a licensed or certified midwife or nurse midwife;
   (d) medical social services by licensed or trained social workers, psychologists or counselors;
   (e) nutrition services provided by a licensed dietitian;
   (f) medical supplies attendant to the above services.

Provided further, that in determining the limit of benefits for services in (a) through (e) above:

1. each visit by a member of a home health care team (other than a home health aide) will be counted as one home health care visit; and
2. four hours or less of home health aide service will be counted as one home health care visit. Charges for more than 120 home health care visits in a calendar year will not be covered.

(7) Charges made by a hospice for hospice care expense incurred by a terminally ill covered person during a hospice benefit period.

(8) Charges for physician's professional services.

(9) Charges for professional ambulance service in connection with an emergency medical condition. Covered medical expense for the service is limited to charges for land transportation to the nearest hospital equipped to render treatment for the condition. Air transportation is covered only when medically necessary.

(10) Charges for covered drugs requiring a written prescription and not covered under any of the preceding paragraphs. Injectable insulin and syringes for its administration are considered drugs under this paragraph. Participants in the Medical with Prescription Drug option should refer to the “Prescription Drug Program” section for additional details.

(11) Charges for services of a licensed or certified nurse practitioner, midwife, nurse midwife or nurse anesthetist acting within the scope of his or her license.

(12) Charges for services of licensed physical, occupational, respiratory, rehabilitation and speech therapists. Such services must be rendered on an outpatient basis. However, they may be rendered in the covered person's home if done as part of a home health care plan. Covered Medical Expenses for such services are limited to 60 days in a calendar year. Each therapist visit will be counted as one day. This day limit is a combined limit for all therapists listed.

(13) Charges for: the transfusion or dialysis of blood, the cost of whole blood, blood components and the administration thereof.

(14) Charges for oxygen and equipment for its administration and other durable medical equipment. The option to rent or purchase any such equipment must be reviewed by the Plan for necessity and appropriateness before charges will be considered a covered medical expense.

(15) Charges for the use of radium and radioactive isotopes.

(16) Charges for non-dental prosthetic devices to replace natural body parts. Replacement of such a device is covered only if required by the covered person's physical change, or because the prosthesis is no longer functional due to wear or damage.

(17) Charges for anesthesia and its administration, x-rays and laboratory work, casts, splints, trusses and braces.

(18) Charges for an on-site nursing assessment by an RN, if ordered by the Plan's claims administrator.

(19) Charges for private duty nursing on an outpatient basis. Covered Health Care Expenses are limited to 70 shifts in a calendar year, where eight hours of services count as one shift.
(20) Charges for chiropractic care services performed by chiropractors, subject to a 12-visit maximum in a calendar year. (Note: The 12-visit limit is a combined in- and out-of-network limit.)

(21) Charges for accidental injury, other than a chewing injury, to sound natural teeth; includes all dental work, surgery, and orthodontic treatment to repair teeth damaged due to injury; if crowns, dentures, bridgework, or appliances are installed due to injury, only charges for the first crown, denture, bridgework, or appliance are covered.

(22) Charges for surgical treatment of temporomandibular joint dysfunction; charges for non-surgical temporomandibular joint dysfunction not to exceed a $1,000 lifetime maximum benefit, including charges for appliances.

(23) Charges for surgical services for morbid obesity, including gastroplasty and gastric bypass surgery only if:

1. presence of severe obesity, defined as either:
   a) body mass index (BMI) exceeding 40; or
   b) BMI greater than 35 in conjunction with any of the following co-morbidities:
      i. coronary heart disease; or
      ii. type 2 diabetes mellitus; or
      iii. clinically significant obstructive sleep apnea; or
      iv. medically refractory hypertension (blood pressure > 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management); and

2. patient has completed growth (18 years of age or documentation of completion of bone growth); and

3. patient has attempted weight loss in the past without successful long-term weight reductions; and

4. patient has participated in a consistent program that is physician-supervised with integrated components of a dietary regimen, appropriate exercise and behavioral modification and support; and

5. an evaluation has been performed by a multi-disciplinary team with medical, surgical, psychiatric and nutritional expertise, and

6. for patients who have a history of severe psychiatric disturbance (schizophrenia, borderline personality disorder, suicidal ideation, severe depression) or who are currently under the care of a psychologist/psychiatrist or who are on psychotropic medications, a pre-operative psychological evaluation and clearance is necessary in order to exclude patients who are unable to provide informed consent or who are unable to comply with the pre- and postoperative regimen. Please note that the presence of depression due to obesity is not normally considered a contraindication to obesity surgery.

Note: Effective January 1, 2016, there will be a maximum of one procedure per lifetime.

(24) Charges for outpatient cardiac rehabilitation.

(25) Charges for vasectomies and tubal sterilizations.

(26) Charges for contraceptive devices, including diaphragms, IUDs, and Norplant.

(27) Charges for habilitative and rehabilitative care for treatment of autism spectrum disorders

(28) Charges for orthognathic surgery – please contact the claims administrator for additional information;
Charges for wigs and other scalp hair prosthesis, up to $350 - please contact the claims administrator for additional information.

Prescription Drug Program

The program described here applies to participants in the Medical with Prescription Drug option.

Prescription drug benefits for Medicare-eligible retirees are provided by a Liberty Mutual-sponsored Medicare Part D prescription drug plan that is available exclusively to participants in the Plan’s Medical with Prescription Drug option. The Plan offers more coverage than a standard Medicare Part D plan.

Prescription drug benefits are administered through SilverScript Insurance Company and administered by CVS/caremark. CVS Specialty Pharmacy is the specialty pharmacy provider.

You may receive information from other, individual private Medicare Part D prescription drug plans available in your geographic area, as well as information from Medicare. Such materials do not describe the benefits available through the Plan’s Part D prescription drug plan. You may choose one of these individual plans or the Liberty Mutual-sponsored plan, but not both, based on your individual needs. If you select an individual prescription drug plan, your coverage will automatically be changed to the Liberty Mutual Medical Only plan and you will not be able to change back to the Medical with Prescription Drug option.

If you change coverage and disenroll from the Medical with Prescription Drug option, you may not re-enroll in that option at any time in the future. If you disenroll from the Plan altogether, you may never re-enroll.

For coverage through SilverScript:

- **You don’t need to individually enroll in Medicare Part D or pay a separate Medicare Part D premium**. Prescription coverage will continue to be part of your monthly Plan premium and SilverScript will administer the plan according to the rules set by the Centers for Medicare and Medicaid Service (CMS).
- **You do not need to pay a deductible and there is no “coverage gap” or “donut hole.”** The Plan’s coverage “wraps” around the “coverage gap” or “donut hole” that many Medicare Part D prescriptions plans have.
- **You'll continue to pay a coinsurance** (with a maximum amount per prescription) based on whether your prescription is a generic, preferred brand, or non-preferred brand.
- **You’ll continue to have both a retail and a mail order pharmacy option to purchase your prescriptions.**
- **Once enrolled for coverage, each plan participant will receive a Welcome Kit and ID card from SilverScript.**

Most retirees will pay the Plan premium. However, some retirees may have to pay an extra amount in addition to the monthly Plan premium because of their yearly income. Extra amounts will be charged to individuals, or married couples filing separately, whose income is above $85,000, or for married couples filing jointly with incomes above $170,000. If you have to pay an extra amount, Social Security—not your Medicare plan or Liberty Mutual—will send a letter telling you what the extra amount will be and how to pay it. No matter how you usually pay your Plan premium, the extra amount will be withheld from your Social Security or Office of
Personnel Management benefit check. If your benefit check isn’t enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium. If you have any questions about this extra amount, contact Social Security at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call 1-800-325-0778.

**Important Note:** SilverScript must have your Medicare Health Insurance Claim Number (HICN) on file in order for your coverage to be effective. While SilverScript has this information for many participants, if you need to provide your HICN, SilverScript will contact you directly. Please provide the HICN to SilverScript as quickly as possible so that your prescription drug coverage can take effect.

SilverScript has a toll-free member services telephone number for your questions on the prescription drug program, including the list of drugs: 1-888-644-0334. Or you may obtain information on the SilverScript website: www.caremark.com. If you are a first-time visitor to the site, please take a moment to register and have your member ID and your prescription number available.

The program has three components:
- a network of retail pharmacies
- a mail-order service
- a specialty pharmacy program

**Your Costs**
The amount you pay for a covered drug will depend on:

- **The drug tier for your drug.** Each covered drug is in one of three drug tiers. Each tier may have a different cost-sharing amount. The chart below explains what types of drugs are included in each tier and shows how costs may change with each tier.

<table>
<thead>
<tr>
<th>Tier</th>
<th>Includes</th>
<th>Helpful tips</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic Drugs</td>
<td>This tier includes many commonly prescribed generic drugs and may include other low-cost drugs.</td>
<td>Use Tier 1 drugs for the lowest cost-sharing amount.</td>
</tr>
<tr>
<td>Tier 2: Preferred Brand Drugs</td>
<td>This tier includes preferred brand-name drugs.</td>
<td>Drugs in this tier will generally have lower cost-sharing amounts than non-preferred drugs.</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred Brand Drugs</td>
<td>This tier includes non-preferred brand-name drugs.</td>
<td>Many non-preferred drugs have lower-cost alternatives in Tiers 1 and 2. Ask your doctor if switching to a lower-cost generic or preferred brand-name drug may be right for you.</td>
</tr>
</tbody>
</table>

- **Your coverage stage.** SilverScript has different stages of coverage. In each stage, the amount you pay for a drug may change. The following table provides a summary of your benefit, including cost-sharing information for your coverage.
You will pay the following until your total yearly drug costs (what you and the plan pay) reach $3,310:

<table>
<thead>
<tr>
<th>Tier</th>
<th>Retail One-Month (31-day Supply)</th>
<th>Retail Three-Month (90-day Supply)</th>
<th>Mail Three-Month (90-day Supply)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1: Generic Drugs</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>$60 maximum</td>
<td>$180 maximum</td>
<td>$120 maximum</td>
</tr>
<tr>
<td>Tier 2: Preferred Brand Drugs</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
<td>30% coinsurance</td>
</tr>
<tr>
<td></td>
<td>$70 maximum</td>
<td>$210 maximum</td>
<td>$140 maximum</td>
</tr>
<tr>
<td>Tier 3: Non-Preferred Brand Drugs</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>$100 maximum</td>
<td>$300 maximum</td>
<td>$200 maximum</td>
</tr>
</tbody>
</table>

Not all drugs are available as a 90-day supply, and not all retail pharmacies offer a 90-day supply. Please refer to your Pharmacy Directory (mailed to you separately from SilverScript as part of your Welcome Kit) or contact SilverScript Customer Care at 1-888-644-0334. You may choose to receive up to a 90-day supply of certain maintenance drugs (medications taken on a long-term basis) through our mail-order pharmacy. There is no charge for standard shipping.

After your total yearly drug costs reach $3,310, you will pay no more than the cost-sharing amounts as shown in the table above in the Initial Coverage stage (note: for Non-Preferred Brand Drugs, your coinsurance will decrease from 50% to 45%) until your yearly out-of-pocket drug costs reach $4,850.

After your yearly out-of-pocket drug costs (what you and others pay on your behalf, including manufacturer discounts but excluding payments made by your Medicare prescription drug plan) reach $4,850, you will pay the greater of 5% coinsurance or:

- a $2.95 minimum coinsurance payment for covered generic drugs (including brand drugs treated as generics), with a maximum not to exceed the standard coinsurance during the Initial Coverage stage
- a $7.40 minimum coinsurance payment for all other covered drugs (Preferred Brand and Non-Preferred Brand Drugs), with a maximum not to exceed the standard coinsurance during the Initial Coverage stage.

Long-Term Care (LTC) Pharmacy
Residents of a long-term care facility using an in-network LTC pharmacy will pay the cost sharing amount for a one-month supply at retail for each stage noted in the above chart. It is important to note that under the terms of the Plan, your prescription will be filled automatically with a generic drug, if one is available, unless your doctor has written “dispense as written” on the prescription.
CVS/caremark Pharmacy Mail-Order Service
If you need a medication on long-term basis, you will save money using the CVS/caremark Pharmacy mail-order service. CVS/caremark will deliver a 90-day supply of your medication right to you.

Participating Pharmacies
For a current listing of pharmacies that participate in the SilverScript network, or for information on participating pharmacies in your area, call SilverScript at 1-888-644-0334 or visit the SilverScript website at www.caremark.com. Please note that if you use a participating pharmacy, but do not provide your SilverScript participant information, you will be responsible for paying for the prescription, and then submitting a claim to SilverScript. Your reimbursement will be for the SilverScript contracted amount, less the coinsurance, not the full price. If you have the pharmacy reprocess your purchase within seven days of the original date of the purchase, then your reimbursement would be for your purchase price, less your coinsurance.

Non-Participating Pharmacies
You must use SilverScript network pharmacies to fill your prescriptions. Covered Medicare Part D drugs are available at out-of-network pharmacies only in special circumstances, such as illness while traveling outside of the plan’s service area where there is no network pharmacy. You may incur additional costs for drugs received at an out-of-network pharmacy. Please contact SilverScript Customer Care at 1-888-644-0334 for more details.

IMPORTANT INFORMATION

- The service area for this plan is all 50 states, the District of Columbia, and Puerto Rico. You must live in one of these areas to join this plan. If SilverScript no longer offers services in the area in which you reside, you will be notified in writing.

- Your plan uses a formulary—a list of covered drugs. SilverScript may periodically add or remove drugs, make changes to coverage limitations on certain drugs, or change how much you pay for a drug. If any formulary change limits your ability to fill a prescription, you will be notified in writing before the change is made.

- The plan may require you to first try one drug to treat your condition before it will cover another drug for that condition.

- Your health care provider must get prior authorization from SilverScript for certain drugs.

- If the actual cost of a drug is less than the normal cost-sharing amount for that drug, you will pay the actual cost, not the higher cost-sharing amount.

- If you request an exception for a drug and SilverScript approves the exception, you will pay the Non-Preferred Brand Drug cost-share for that drug. This plan provides coverage for Medicare Part B medications, as well as several categories of other non-Part D medications that are not normally covered by a Medicare prescription drug plan. The amounts paid for these medications will not count toward your total drug costs or total out-of-pocket expenses. Please see the formulary that will be included in the Welcome Kit mailed to you once you are enrolled for coverage.
Formulary
The Plan’s drug program through SilverScript includes a voluntary “formulary” feature. A formulary is a list of commonly prescribed medications that are preferred based on their safety, clinical efficacy and cost-effectiveness to the Plan. Please see the formulary list included in the Welcome Kit which will be mailed to you once you are enrolled for coverage.

CVS Specialty Pharmacy
CVS Specialty Pharmacy, is designed to help you meet the particular needs and challenges of using certain medications, many of which require injection or special handling, called “specialty medications.” These medications are used to treat conditions such as MS, Hepatitis C, Rheumatoid Arthritis, among others.

If your physician prescribes a drug that falls into the specialty pharmacy definition, that drug can be purchased through CVS Specialty Pharmacy.

Benefits of using CVS Specialty Pharmacy include:
- 24/7 access to pharmacists who are trained in specialty medications, their side effects, and the conditions they treat.
- Expedited delivery-to your home or your doctor’s office for all your specialty prescription medications.
- Some supplemental supplies, such as needles and syringes, required to administer the medication will be included at no additional charge.
- Scheduling of refills and coordination of services with home care providers, case managers, and doctors or other healthcare professionals.

You may be eligible to receive specialty pharmacy services through CVS Specialty Pharmacy if you are taking a covered specialty medication. To find out if you are eligible, call CVS Specialty Pharmacy at 1-888-644-0334, available 24 hours a day, seven days a week.

Special Provisions
- **Step Therapy:** This program uses clinical logic to perform an automated check of your medical profile and drug history to determine whether or not you have tried a clinically appropriate and available generic or lower cost drug before providing coverage of the brand or met other clinical criteria for coverage.

Prior Authorization for Certain Drugs
Certain medications that are covered by the Plan have multiple uses or a very high cost, thus restrictions on the use or quantity may apply. In those cases, the covered person must receive pre-authorization from SilverScript before the prescription can be filled.

You may currently have a prescription for which you have obtained a prior authorization or prior approval under your current prescription drug coverage. If your medication also requires a prior authorization under SilverScript, you may need to obtain a new approval. Existing authorizations may not be carried over into your new prescription drug coverage. Review your formulary when you receive it or call SilverScript Customer Care at 1-888-644-0334 to determine if your drug requires a prior authorization.

If you require a new approval, call SilverScript Customer Care after your membership in the plan becomes effective. SilverScript will then start the prior authorization process with your provider. Please note, due to differences in plan rules, it is possible that your prior authorization may not be approved. In that case, you may need to work with your provider to find an alternative drug.

If you run out of your medication before your prior authorization is processed, you may be given up to a 31-day temporary supply of a Part D medication at your pharmacy.

If you fill a prescription at the retail level for a drug that requires pre-authorization, you or your pharmacist can ask your physician to call SilverScript at 1-888-644-0334 to initiate the review process for you. It typically takes
three business days. You and your physician will be notified when the review process is completed. If your medication is not approved for coverage under the Plan, you will have to pay the full cost of the drug.

If you choose instead to fill your prescription through the mail-order service, the pharmacist will contact your doctor to set up the pre-authorization, if appropriate, and your prescription will be filled and mailed to you or you may appeal.

For the list of drugs that require pre-authorization, please refer to the formulary list included in your Welcome Kit.

**Dose Management Program**
Dose Management uses clinical guidelines to provide coverage for additional drug quantities through a pre-authorization process.

Under the Dose Management Programs, the following may apply:

- **Quantity Limits** restrict the number of tablets covered per month.

For the list of drugs that currently have a quantity limit, please refer to the formulary list included in your Welcome Kit.

**Medication Therapy Management (MTM) Program**
The Medication Therapy Management (MTM) Program is a free service offered by SilverScript to help you manage your medications. You may be invited to participate in a program designed for your specific health and pharmacy needs. You may decide not to participate, but it is recommended that you take full advantage of this covered service if you are selected. Contact SilverScript for more details.

**Qualifying for Extra Help to Pay for Prescription Drug Premiums and Costs**
To see if you qualify for extra help with your prescription drug premium and or costs, call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day/7 days a week (TTY users should call 1-877-486-2048); the Social Security Office at 1-800-772-1213 between 7 a.m. and 7 p.m., Monday through Friday (TTY users should call 1-800-325-0778); or your State Medicaid Office. If you qualify for Extra Help, you will continue to pay the monthly Medical with Prescription Drug option premium to Liberty Mutual, but SilverScript will mail you a monthly check representing the amount of Medicare assistance should you qualify for help. In addition, if you qualify for assistance, your prescription drug cost-sharing amounts may be lower than the standard plan benefit.

**Preventive Care**

**Charges for the Newborn**
A baby is covered as a dependent from the date of birth provided that dependent coverage is in force at that time, or is added within 60 days of the birth as a status change. This includes coverage for hospital charges for routine nursery care during the mother's confinement, physician's charges for circumcision, and the initial in-hospital physician's visit.

**Benefits for Children Through Age 18**
Coverage under the Medical with Prescription Drug option is provided for outpatient preventive care services from the date of birth through 18 years of age, including physical examination, history, measurements, sensory screening, neuropsychiatric evaluation and development screening and assessment according to an age-based schedule.

These services shall also include hereditary and metabolic screening at birth, appropriate immunizations and tuberculin tests, hematocrit, hemoglobin or other appropriate blood tests, and urinalysis as recommended by
the physician. The services are covered at 100% without an annual deductible. The usual deductible and coinsurance apply, along with all other applicable provisions, limitations, exclusions and exceptions of the Plan.

Coverage For Health Examinations (Age 19 and Older)
Under the Medical with Prescription Drug option, members may receive an annual health assessment, limited to one visit per calendar year, with services covered at 100% without an annual deductible. Routine immunizations, tests, and lab fees administered as preventive services during the health assessment are included.

Annual Flu Prevention
Under the preventive services benefits, members may receive an annual flu shot, limited to one shot per calendar year, with services covered at 100% without an annual deductible. Office visits associated with the flu shot, other than for an annual physical, will be subject to the annual deductible and coinsurance.

Cancer Screenings
Under the preventive services benefits, women may receive an annual examination by a gynecologist. The office visit and all lab tests administered during the visit, including routine PAP lab charges, are covered at 100%. Please note that mammogram screenings are usually performed separately from the annual examination and are separately covered at 100%. The Plan follows the American Cancer Society’s recommendations for mammography screening, as follows:

• for women age 35 through 39, one baseline mammogram;
• for women age 40 or older, one mammogram every year. More frequent mammograms conducted upon the recommendation of a physician will be subject to the annual deductible and coinsurance.

Routine PSA screenings are covered preventive care services for males age 40 and older. Up to one screening per calendar year is covered under the preventive care services provision.

Colon and Rectal Cancer screenings are considered covered preventive care services for members age 50 and older as follows:

• fecal occult blood test (FOBT), one per member every year;
• sigmoidoscopy, one per member every five years;
• colonoscopy, one per member every ten years;
• double-contrast barium enema, one per member every five years.

The benefits provided under the health examination provision are subject to all other applicable provisions, limitations and exceptions of the Plan.

Coverage for Organ Transplants
Except as provided below, benefits for organ transplants are payable on the same basis as any other sickness or injury.

Covered Health Care Expenses for charges incurred by a covered person in connection with an organ transplant will include charges incurred by the donor, including charges for transportation of the organ(s), to the extent that the charges are not covered by the donor’s plan of coverage or insurance. Covered Health Care Expenses will not include charges incurred by the covered person as an organ donor.
Coverage for Infertility Benefits

As used in this provision, "infertility" means the condition of a presumably healthy individual who is unable to conceive or produce conception during a period of one year and has been under the care of a physician.

Benefits will be paid for reasonable charges incurred by a covered person for the diagnosis and treatment of infertility, to the same extent as those provided for any other pregnancy-related expense. Benefits provided under the Plan, however, are determined per covered person. For instance, if a retiree and his spouse were each covered persons under the Plan, the maximum benefits available under the Plan, as described below, for each of them as a covered person may not be combined or shared to increase a covered person’s limits to an amount greater than an individual limit. Pre-approval is required in advance of receiving infertility treatment. For additional information, please contact your claims administrator at the number on your ID card.

The following procedures will be covered, subject to a $10,000 lifetime maximum for non-drug treatments and a $10,000 lifetime maximum for drug treatments:

- Artificial Insemination and Intrauterine Insemination;
- In Vitro Fertilization and Embryo Placement;
- Assisted Reproductive Technologies (ART), Gamete Intra-Fallopian Transfer (GIFT) and Intra Cytoplasmic Sperm Injection (ICSI);
- Sperm, egg and/or inseminated egg procurement and processing, and banking of sperm or inseminated eggs, to the extent such costs are not covered by the donor's insurer, if any; and
- Cryopreservation of embryos, limited to 12 months

Benefits will not be paid for:

- Surrogacy;
- Reversal of voluntary sterilization;
- Any other experimental infertility procedure unless the procedure becomes recognized by the American Fertility Society or the American College of Obstetrics and Gynecology and the procedure is performed after that date.
- Any charge if the covered person previously underwent a voluntary sterilization.
- Charges for recruitment of or reimbursement to egg donors, any costs attributed as “enrollment fees” in any donor egg program or charges for the physical or psychological screening of a potential egg donor.
- Charges for any treatment that could not be performed on a covered person of that gender.

Participants in the Medical with Prescription Drug option pay the applicable prescription co-pay for outpatient fertility drugs purchased at SilverScript participating pharmacy or through mail service, subject to the $10,000 lifetime maximum for drug treatments.

The benefits provided under this provision are subject to all other applicable provisions, limitations and exceptions of the Plan.

Exclusions

The following are not Covered Health Care Expenses:

(a) charges for services and supplies that are not medically necessary;
(b) charges for services or supplies to the extent that benefits are available for the services or supplies elsewhere under the Plan or under any other plan or group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group offered by the Company whether or not a covered person is covered for such benefits;

(c) charges for services or supplies for which benefits are not payable because of deductible, coinsurance, or co-payment provisions under this Plan, including the prescription drug program, or under any other plan or group insurance, group prepayment coverage or other arrangement of coverage for individuals in a group offered by the Company;

(e) charges for routine eye examinations; eye refractions; vision therapy; radial keratotomy; eyeglasses; contact lenses, except the first pair following cataract surgery and only if vision can be corrected to 20/40 or better with contact lenses but not with conventional lenses (eyeglasses); or other vision aids;

(f) charges for cosmetic surgery other than:
   • surgery performed to correct a congenital disease or anomaly of a dependent child;
   • reconstructive surgery to restore tissue damaged by an injury or sickness; or
   • for covered persons receiving benefits for a medically necessary mastectomy who elect breast reconstruction after the mastectomy; coverage will be provided for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas.

(g) charges for any services rendered by a member of the covered person's immediate family or a person who lives in the covered person's home;

(h) charges for treatment to the teeth or gums except expense incurred for treatment of accidental injury, other than a chewing injury, to sound natural teeth;

(i) charges for non-surgical treatment of temporomandibular joint dysfunction that exceed the lifetime maximum benefit of $1,000, including appliances;

(j) charges for immunizations, or for tests and exams that are not due to or part of the treatment of an injury or sickness unless provided under the section titled Preventive Care;

(k) charges for vitamins or food supplements (the only exception is prenatal vitamins, which are covered when prescribed by a physician), Renova, fluoride, non-prescription over-the-counter drugs, medicines and supplies, experimental drugs or drugs limited by law to investigational use and any charges for the administration of such substances;

(l) charges for private duty nursing services in a hospital or any other facility;

(m) charges for gender reassignment surgery;

(n) charges incurred by a covered person as an organ donor;

(o) charges incurred or treatment rendered unless the covered person is under a legal obligation to pay for such treatment;

(p) charges for expenses incurred due to accidental injury or sickness that arises out of or in the course of employment or for which benefits are payable under a Workers' Compensation Law or other similar law; or where benefits are payable under no-fault automobile coverage or similar legislation if you could
elect it, or could have it elected for you

(q) charges for custodial care;

(r) charges for reversal of a voluntary surgical sterilization;

(s) charges for items used for personal comfort and/or that are useful or that improve the covered person's household, whether or not recommended by a physician, including but not limited to:

- air conditioners, humidifiers and air cleaners or filtration systems,
- all types of exercise equipment such as exercise bicycles and treadmills,
- whirlpools and saunas,
- lift chairs and all types of beds except hospital beds covered as durable medical equipment,
- vans, van lifts and alterations to motor vehicles, or
- stair lifts, ramps and alterations and/or remodeling of any household;

(t) charges for care, treatment, services and medical supplies that are primarily for dietary control, including but not limited to any exercise and/or weight reduction programs, whether or not recommended by a physician; with the exception of surgical services for morbid obesity including gastroplasty and gastric bypass surgery covered under certain conditions as detailed in the “Covered Health Care Expenses” section;

(u) charges for any testing, training or rehabilitation for educational, developmental or vocational purposes, including but not limited to charges for the diagnosis or treatment of an Academic Skills Disorder, including a Developmental Arithmetic Disorder, a Developmental Expressive Writing Disorder, a Developmental Articulation Disorder, a Developmental Expressive Language Disorder, or a Developmental Receptive Language Disorder, whether or not recommended by a physician;

(v) charges for marriage counseling and/or sexual therapy;

(w) charges for exercise programs that are primarily used to maintain a level of health, whether or not recommended by a physician;

(x) charges for services rendered by a chiropractor that exceed the maximum benefit of 12 visits per calendar year;

(y) charges for travel or transportation to obtain medical services, treatment or supplies except charges for professional ambulance service as set forth in subparagraph (9) under “Covered Health Care Expenses”;

(z) charges for dentures except as required to replace sound natural teeth lost because of injury not caused by biting or chewing on food or other objects;

(aa) charges for dentistry or dental x-rays. Note: The only exception is for employees who retired prior to 1/1/1984 who are covered for necessary medical expenses incurred for treatment of periodontal disease or for the removal of impacted teeth. Employees who retired on or after 1/1/1984 should refer to their applicable dental plan, if enrolled;

(bb) charges for any care, treatment, services or supplies that are:
  - not approved or accepted as essential to the treatment of an Injury or Sickness by any of the following: The American Medical Association, the U.S. Surgeon General, the U.S. Department of Public Health, or the National Institute of Health; or
  - not recognized by the medical community as potentially safe and efficacious for the care and
treatment of the injury or sickness;

(cc) charges incurred outside the United States if:
  • the covered person traveled to such location to obtain medical services, drugs or supplies; or
  • such services, drugs or supplies are unavailable or illegal in the United States;

(dd) charges for speech therapy; charges are covered only when such therapy is administered by a provider licensed to administer speech therapy to a covered person whose previously unimpaired speech is affected by an injury or sickness, or to a dependent child as part of that child's treatment to correct a congenital disorder;

(ee) charges for multiple surgical procedures, whether or not related, in excess of 100% of the R&C fee for the greater procedure and 50% of the R&C fee for each lesser procedure during the same operative session;

(ff) charges of an assistant surgeon or surgical assistant in excess of the lesser of:
  • the actual billed charge; or
  • 20% of the reasonable and customary charge for the surgery;

(gg) charges for thermography or its interpretation;

(hh) charges for birth preparation classes, such as Lamaze;

(ii) charges for a preferred or non-preferred brand name drug for which there is a generic substitution;

(jj) charges for the difference in cost between a preferred or non-preferred brand name drug and the generic drug if a therapeutically equivalent generic drug is available but the physician has written “dispense as written” on the prescription;

(kk) charges for routine hearing tests or hearing aids;

(ll) charges for autologous (own) or directed blood donation (selected donor) and blood storage prior to surgery when surgery requires transfusion;

(mm) charges for acupuncture;

(nn) charges for orthopedic shoes, foot orthotics, or other devices to support the feet;

(oo) charges for routine foot care;

(pp) charges for prescription drugs where an equivalent over-the-counter drug is available; and

(qq) $200 per visit emergency room charge.

Personal Health Support

UnitedHealthcare provides a program called Personal Health Support designed to encourage personalized, efficient care for you and your covered Dependents. Personal Health Support Nurses center their efforts on prevention, education, and closing any gaps in your care. The goal of the program is to ensure you receive the most appropriate and cost-effective services available.
If you are living with a chronic condition or dealing with complex health care needs, UnitedHealthcare may assign to you a primary nurse, referred to as a Personal Health Support Nurse, to guide you through your treatment. This assigned nurse will answer questions, explain options, identify your needs, and may refer you to specialized care programs. The Personal Health Support Nurse will provide you with their telephone number so you can call them with questions about your conditions, or your overall health and well-being. Personal Health Support Nurses will provide a variety of different services to help you and your covered family members receive appropriate medical care. Program components are subject to change without notice.

Medicare

It is important that each covered person enroll for the full benefits of Medicare as soon as the person becomes eligible for Medicare. The Plan does not cover charges payable by Medicare. In addition, the Plan will pay no more after Medicare than it would pay as primary payer. For example, if Medicare has already paid 80% of a covered charge, the Plan will pay nothing further. If you are eligible for Medicare, the Plan will apply the coordination of benefits rule whether or not you have actually applied for Medicare coverage. Covered expenses that you pay will be applied toward your Plan out-of-pocket maximum.

When the Plan ceases as primary payer for you upon Medicare entitlement due to disability or the attainment of age 65, or ceases as primary payer for your spouse or dependents, the above Medicare exclusion will apply to the affected person. Therefore, you should consult with your local Social Security office as to the best time to enroll in Medicare so that comprehensive medical coverage continues without interruption.

Medicare Part D Prescription Drug Coverage

The Company has determined that the prescription drug coverage provided under the Plan (except for the Medical Only option which does not provide coverage for prescription drugs) is, on average for all participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay.

Enrolling in another Medicare Part D prescription drug program at any time will cause you and your Medicare-eligible family members to be moved automatically into the Medical Only option and you will not be allowed to change to the Medical with Prescription Drug option at any time in the future.

Please note: If a retiree or covered dependent upon reaching age 65 or becoming Medicare eligible elects the Medical Only option, this election will apply to all participants upon reaching Medicare eligibility with no opportunity to change to the Medical with Prescription Drug option in the future.

Coordination of Benefits

If a member of your family is covered by another employer’s benefit plan, there may be some duplication of benefit coverage between the Plan and the other plan. This “coordination of benefits” (or COB) provision describes how benefits are paid in such cases. Its purpose is to ensure that, when benefits are payable under both the Plan and another group plan or plans, or Medicare, the total benefits paid do not exceed the total that would be payable under the Plan in the absence of other coverage. Note that the prescription drug benefit program does not coordinate benefits with other plans.

To determine how plans coordinate benefits, one plan is considered primary and the other is considered secondary. The primary plan pays benefits first, up to that plan’s limits. The secondary plan will not pay benefits until the primary plan pays a portion of or denies a claim. How a plan is determined to be primary is explained in the “Non-Duplication of Benefits” section below.

The word "plan" as used in this provision applies to any of the following which provides benefits or services
for medical care:
• group insurance or group prepayment coverage; or
• coverage for persons in a group (whether or not on an insured basis); or
• governmental programs and coverage required or provided by statute including, but not limited to
  automobile no-fault insurance and Medicare.

The word "plan" applies separately to:
• each policy or other arrangement for benefits or services; or
• the portion of such policy or other arrangement that reserves the right to consider other plans in
determining its benefits.

The term "this plan" means the group medical benefits provided by the Company and described in this
Summary Plan Description.

"Allowable Expense" means any necessary, reasonable, and customary item of expense at least a part of which
is covered by one of the plans that covers the person for whom claim is made (claimant). When a plan provides
benefits in the form of services rather than cash payments, the reasonable cash value of each service rendered
will be deemed to be both an allowable expense and a benefit paid.

In applying this provision, it will be presumed that all affected retirees and dependents have chosen to assert
their rights under other plans of benefits, including automobile no-fault laws based on the actual coverage that
has been selected.

Non-Duplication of Benefits
A plan without a COB provision is always the primary plan. The primary plan is the plan that pays its benefits
first. If all plans have COB provisions, the following rules apply:

• Medicare is always primary for retirees and spouses and domestic partners age 65 and older.

• The Plan is primary for covered retirees’ spouses/domestic partners under age 65. The Plan
  ceases as primary payer for you upon Medicare eligibility due to disability regardless if you
  are enrolled or not.

• Any other plan covering a dependent as an employee is the primary plan for that person. For
  example, if your spouse or domestic partner is covered by a plan offered by his or her employer, then
  that plan will be primary for your spouse or domestic partner.

• If your child is covered by this plan and your spouse’s plan or your domestic partner’s plan as
  a dependent, then the birthday rule determines which plan is primary. Under the birthday rule,
  the plan of the parent whose birthday falls earliest in the calendar year is your child’s primary plan. If
  both parents have the same birthday, the parent who has been covered longer has the primary plan. If
  your spouse’s plan or domestic partner’s plan does not have the birthday rule, then the spouse’s plan
  or the domestic partner’s plan is primary.

• If parents are divorced or separated and a court decree establishes financial responsibility for
  medical care of a child, then the plan of the parent assigned that responsibility will be that child’s
  primary plan. In the absence of a court decree and when not remarried, the plan of the parent with
  custody will pay benefits before the plan of the other parent. If the parent with custody has remarried
  or entered into a domestic partnership and the stepparent’s or domestic partner’s plan also covers
  the child, the plan of the parent with custody will pay first, then the plan of the stepparent or domestic
  partner will pay next, and the plan of the parent without custody will pay last.

There are two other rules to keep in mind regarding non-duplication of benefits. First, when an individual has
coverage from two employers -- one a current employer, and the other a previous employer -- the current
employer’s plan is primary. Second, when the preceding rules do not resolve which plan is primary, the plan covering the individual the longest is primary.

When the Plan is primary, the Plan pays benefits as if it were the only plan. After the Plan pays its benefits, or denies a claim, you may file a claim for any unpaid amounts with the secondary plan.

Here is how the Plan coordinates benefits when it is the secondary plan:

- The Plan determines the benefit that would be paid if it were the only plan. This includes applying the appropriate co-pay, deductible, coinsurance, and all other benefit limitations.
- The amount of benefit paid by the primary plan is subtracted, or “carved out” from any benefit that would be paid by the Plan. This means that when the Plan is secondary, it will only pay the difference, if any, between its usual benefit and the benefit paid by the primary plan (including Medicare, if applicable).

When the Plan coordinates with Medicare, it is called “maintenance of benefits.” Here is a summary of how it works, assuming you are enrolled in the Medical with Prescription Drug option and this is your first hospital charge for the year:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Original billed amount from hospital</td>
<td>$2,000</td>
</tr>
<tr>
<td>Medicare approved charge</td>
<td>$1,500</td>
</tr>
<tr>
<td>Medicare 2016 hospital deductible</td>
<td>$1,184</td>
</tr>
<tr>
<td>Paid by Medicare</td>
<td>$212</td>
</tr>
</tbody>
</table>

For coordination of benefits, Liberty would consider the following:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare approved charge</td>
<td>$1,500</td>
</tr>
<tr>
<td>Liberty deductible</td>
<td>$300</td>
</tr>
<tr>
<td>Liberty coinsurance</td>
<td>$1,200</td>
</tr>
<tr>
<td>Amount Liberty would have paid in the absence of Medicare</td>
<td>$960</td>
</tr>
<tr>
<td>Subtract amount already paid by Medicare</td>
<td>$212</td>
</tr>
<tr>
<td>Liberty’s payment</td>
<td>$748</td>
</tr>
</tbody>
</table>

Now, in order to determine the balance you pay:

<table>
<thead>
<tr>
<th>Description</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare payment</td>
<td>$212</td>
</tr>
<tr>
<td>Liberty payment</td>
<td>$748</td>
</tr>
<tr>
<td>Total Plan payments</td>
<td>$960</td>
</tr>
<tr>
<td>Medicare approved charge</td>
<td>$1,500</td>
</tr>
<tr>
<td>Subtract total Plan payments</td>
<td>$960</td>
</tr>
<tr>
<td>Retiree payment</td>
<td>$540</td>
</tr>
</tbody>
</table>

The $540 you pay will be applied toward your out-of-pocket maximum of $1,500 for covered charges for the year.
Please note that if your health provider does not take assignment, the Plan will continue to coordinate with Medicare using the Reasonable and Customary charge at the 80th percentile of the HIAA tables.

Therefore, coverage under the Plan and another plan will not likely result in your receiving reimbursement greater than the total that would be payable under the Plan in the absence of other coverage for your health care expenses.

Right to Receive and Release Necessary Information
The Plan has the right, without obtaining consent or serving notice, to release or obtain benefit information needed in order to implement this provision.

Optional Payment of Benefits
If payments should have been made under this Plan but were made under any other plan(s), the Plan may make payments to such other plan(s) to satisfy the intent of the provision. Benefits under this Plan will then be deemed paid. The Plan will no longer be liable for the payments.

Right of Recovery
If payments were made under this Plan that should have been made under any other plan, the Plan has the right to recover such payments. This right may be exercised against any persons to, for or with respect to whom the payments were made, and any insurance companies or other organizations.

Reimbursement and Subrogation
Subrogation applies when the Plan has paid benefits on your behalf for a sickness or injury for which a third party is alleged to be responsible. The right to subrogation means that the Plan is substituted to and shall succeed to any and all legal claims that you may be entitled to pursue against any third party for the benefits that the Plan has paid that are related to the sickness or injury for which a third party is alleged to be responsible.

The following persons and entities are considered third parties:

- A person or entity who is legally responsible for the sickness, injury or damages.
- Any insurer or other indemnifier of any person or entity alleged to have caused or who caused the sickness, injury or damages.
- The Plan Sponsor (for example workers' compensation cases).
- Any person or entity who is or may be obligated to provide benefits or payments to you, including benefits or payments for underinsured or uninsured motorist protection, no-fault or traditional auto insurance, medical payment coverage (auto, homeowners or otherwise), workers' compensation coverage, other insurance carriers or third party administrators.
- Any person or entity that is liable for payment to you on any equitable or legal liability theory.

As a covered person or dependent under the Plan, you must:

- Notify the Plan, in writing, of any potential legal claim(s) you may have against any third party for acts which caused Benefits to be paid or become payable.
- Provide any relevant information/documents requested by the Plan in order to secure the subrogation and reimbursement claim.
- Respond to requests for information about any accident or injuries.
- Make court appearances.
- Obtain the Plan's consent or its agents' consent before releasing any party from liability or payment of medical expenses.
The Plan has the right to terminate your benefits, deny future benefits, take legal action against you, and/or offset from any future benefits the value of benefits the Plan has paid relating to any sickness or injury alleged to have been caused or caused by any third party to the extent not recovered by the Plan due to you or your representative not cooperating with the Plan. If the Plan incurs attorneys' fees and costs in order to collect third party settlement funds held by you or your representative, the Plan has the right to recover those fees and costs from you. You will also be required to pay interest on any amounts you hold which should have been returned to the Plan.

The Plan has a first priority right to receive payment on any claim against a third party before you receive payment from that third party. Further, the Plan's first priority right to payment is superior to any and all claims, debts or liens asserted by any medical providers, including but not limited to hospitals or emergency treatment facilities, that assert a right to payment from funds payable from or recovered from an allegedly responsible third party and/or insurance carrier.

The Plan's subrogation and reimbursement rights apply to full and partial settlements, judgments, or other recoveries paid or payable to you or your representative, no matter how those proceeds are captioned or characterized. Payments include, but are not limited to, economic, non-economic, and punitive damages. The Plan is not required to help you to pursue your claim for damages or personal injuries and no amount of associated costs, including attorneys' fees, shall be deducted from the Plan's recovery without the Plan's express written consent. No so-called "Fund Doctrine" or "Common Fund Doctrine" or "Attorney's Fund Doctrine" shall defeat this right.

Regardless of whether you have been fully compensated or made whole, the Plan may collect from you the proceeds of any full or partial recovery that you or your legal representative obtain, whether in the form of a settlement (either before or after any determination of liability) or judgment, no matter how those proceeds are captioned or characterized. Proceeds from which the Plan may collect include, but are not limited to, economic, non-economic, and punitive damages. No "collateral source" rule, any "Made-Whole Doctrine" or "Make-Whole Doctrine," claim of unjust enrichment, nor any other equitable limitation shall limit the Plan's subrogation and reimbursement rights.

Benefits paid by the Plan may also be considered to be benefits advanced.

If you receive any payment from any party as a result of sickness or injury, and the Plan alleges some or all of those funds are due and owed to the Plan, you shall hold those funds in trust, either in a separate bank account in your name or in your attorney's trust account. You agree that you will serve as a trustee over those funds to the extent of the benefits the Plan has paid.

The Plan's rights to recovery will not be reduced due to your own negligence.

Upon the Plan's request, you will assign to the Plan all rights of recovery against third parties, to the extent of the benefits the Plan has paid for the sickness or injury.

The Plan may, at its option, take necessary and appropriate action to preserve its rights under these subrogation provisions, including but not limited to, providing or exchanging medical payment information with an insurer, the insurer's legal representative or other third party and filing suit in your name, which does not obligate the Plan in any way to pay you part of any recovery the Plan might obtain.

You may not accept any settlement that does not fully reimburse the Plan, without its written approval.

The Plan has the authority and discretion to resolve all disputes regarding the interpretation of the language stated herein.

In the case of your wrongful death or survival claim, the provisions of this section apply to your estate, the personal representative of your estate, and your heirs or beneficiaries.

No allocation of damages, settlement funds or any other recovery, by you, your estate, the personal representative of your estate, your heirs, your beneficiaries or any other person or party, shall be valid if it does not reimburse the Plan for 100% of its interest unless the Plan provides written consent to the allocation.
The provisions of this section apply to the parents, guardian, or other representative of a Dependent child who incurs a Sickness or Injury caused by a third party. If a parent or guardian may bring a claim for damages arising out of a minor's Sickness or Injury, the terms of this subrogation and reimbursement clause shall apply to that claim.

If a third party causes or is alleged to have caused you to suffer a sickness or injury while you are covered under this Plan, the provisions of this section continue to apply, even after you are no longer covered.

The Plan and all administrators administering the terms and conditions of the Plan's subrogation and reimbursement rights have such powers and duties as are necessary to discharge its duties and functions, including the exercise of its discretionary authority to (1) construe and enforce the terms of the Plan's subrogation and reimbursement rights and (2) make determinations with respect to the subrogation amounts and reimbursements owed to the Plan.

**Termination of Coverage**

The personal coverage of a covered retiree will end on the date that any of the following events first occur, subject to any applicable Continuation of Coverage Provisions:

(a) the Plan terminates;

(b) the end of the last period for which a covered retiree makes a required contribution or otherwise failed to pay any required portion of the cost of personal coverage; or

(c) the covered retiree enrolls in a Medicare Part D prescription drug program.

The retiree’s coverage of a covered dependent will end on the date that any of the following events first occur, subject to any applicable Continuation of Coverage Provisions:

(a) status as a dependent ends;

(b) the covered retiree’s personal coverage ends;

(c) dependent coverage is deleted from the Plan;

(d) the end of the last period for which a covered retiree makes a required contribution, if he has canceled his pension deduction authorization or otherwise failed to pay any required portion of the cost of dependent coverage; or

(e) the dependent becomes covered as an employee.

For more information, refer to the “Right to Continue Coverage” information later in this document.

**How to Claim Your Benefits**

**Health Care Claim Forms**

Forms for the Medical with Prescription Drug option are available by contacting UnitedHealthcare directly.

Once you have completed your claim form and attached your itemized bill or original receipt, mail the form directly to UnitedHealthcare at the address shown on the form. Medical bills must be on the doctor's bill form or letterhead, fully itemized with patient's name, dates of treatment, kinds of treatment, i.e., office visit, surgery, injection, etc. "Balance due" bills are not acceptable because they do not include the specifics outlined in this paragraph.
Claims must be submitted within two years from the date that charges are incurred, unless they are delayed by the claimant's legal incapacity, or they will not be paid.

Direct Payment of Benefits
The Plan allows for direct payment of benefits to any provider (doctor, hospital, etc.) regardless of whether such payment is made at the retiree’s request or with his or her consent.

If you assign payment to a provider, your bill must be paid directly to the provider. If an assigned bill is marked paid, the provider must be able to confirm that there is no balance, before a benefit will be sent to the retiree.

To be recognized as a valid assignment of benefits under the Plan, the assignment must reflect the agreement of the covered dependent in that the out-of-network provider will be entitled to all the covered dependent's rights under the Plan and applicable state and federal laws, including legally required notices and procedural reviews concerning those benefits, and that the covered dependent will no longer be entitled to those rights.

If an assignment form does not comply with this requirement, but directs that the benefit payment should be made directly to the out-of-network provider, UnitedHealthcare may in its discretion make payment of the benefits directly to the provider for your convenience, but will treat the covered dependent, rather than the provider, as the beneficiary of the claim. If benefits are assigned or payment to an out-of-network provider is made, the Company reserves the right to offset the benefits to be paid to the provider by any amounts that the provider owes the Company pursuant to “Coordination of Benefits”.

SilverScript Prescription Drug Claim Forms
If you are a participant in the Medical with Prescription Drug option, in most cases you will not need to file claims for prescriptions. Instead you will pay the applicable coinsurance either at a SilverScript participating pharmacy or through the mail service.

Explanation of Benefits
An explanation of benefits (EOB) form is issued after each claim is processed. It lists the dates of services, medical providers, amounts considered, coinsurance level and remaining lifetime maximum benefit. If you have any questions regarding payments, you may call or write the claims administrator at the address and telephone number listed on your EOB. Your questions can be answered more quickly by stating your claim ID number that is located on the EOB.

Women’s Health and Cancer Rights Act Notification (WHCRA)
For covered persons receiving benefits for a medically necessary mastectomy who elect breast reconstruction after the mastectomy, coverage will be provided for reconstruction of the breast on which the mastectomy has been performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and physical complications of all stages of mastectomy, including lymphedemas. This language is intended to satisfy the Women’s Health and Cancer Rights Act annual notice requirement regarding mastectomy-related services available under the Plan.

Qualified Medical Child Support Order (QMSCO)
A “Qualified Medical Child Support Order” may require benefits for a dependent child under the Plan.
Generally, this is a judgment, decree, or order that pertains to divorce. You can obtain a copy of the Plan’s QMSCO procedures, without charge, by calling Benefits Express at 1-800-758-4460.

**Right to Continue Coverage (COBRA)**

It is important that both you and your spouse read this summary. These provisions generally explain COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it.

The federal law known as COBRA requires most employers sponsoring group health plans to offer employees and their families who would otherwise lose group health plan coverage a temporary extension of coverage under the employer’s group health plan. COBRA continuation coverage is continuation of plan coverage when coverage would otherwise end because of a qualifying event, specified below. COBRA continuation coverage must be offered to each person who is a qualified beneficiary, defined as a person who will lose plan coverage because of a qualifying event.

COBRA continuation coverage for the Plan is administered by Benefits Express, for questions call 1-800-758-4460.

**Employee**

Employees covered by this Plan will become qualified beneficiaries and can elect COBRA continuation coverage if Plan coverage is lost because of the following qualifying events: a reduction in hours of employment or termination of employment (for other than gross misconduct), including retirement. Benefits Express, as COBRA administrator, will notify the employee whose coverage would otherwise end because of such a qualifying event that the employee has 60 days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. An employee must elect COBRA continuation coverage following such a qualifying event within 60 days of receiving notice of his or her COBRA election rights from Benefits Express via the COBRA Enrollment Notice. If the employee does not elect COBRA continuation coverage within 60 days of receiving the COBRA Enrollment Notice from Benefits Express, group health plan coverage will end on the date of the qualifying event.

**Spouse and Dependent Children**

Dependent spouses and children covered by this Plan will become qualified beneficiaries and can elect COBRA continuation coverage if Plan coverage is lost because of any of the following qualifying events:

- death of a retiree (see "Dependents of Deceased Retirees" below);
- termination of an employee’s employment (for other than gross misconduct) including retirement, or reduction in hours of employment, or movement to benefits ineligibility status;
- divorce or legal separation of the spouse from an employee;
- child loses "dependent" status as defined under the Plan; or
- retiree entitlement to Medicare.

Newborns and children placed for adoption with a covered retiree during a period of COBRA continuation coverage will be eligible for coverage immediately under a parent’s COBRA coverage as qualified beneficiaries.

In addition, filing a proceeding in bankruptcy under Title 11 of the United States Code can be a qualifying event with regard to the employer from whose employment the covered employee retired. If that bankruptcy results in the loss of retiree coverage within the time period specified under COBRA, the retiree will become a qualified beneficiary with respect to that bankruptcy. The covered spouse and dependent children of the retiree (including surviving spouse and dependent children) will also become qualified beneficiaries if that bankruptcy...
results in the loss of their coverage under the Plan.

Notification
If the qualifying event that will cause a loss of Plan coverage is divorce, legal separation or a child’s loss of dependent status under the Plan, the retiree or a family member must inform Benefits Express at 1-800-758-4460 within 60 days of such a qualifying event. Supporting documentation may be required. For such qualifying events, and the other qualifying events listed under “Spouse and Dependent Children,” Benefits Express, as COBRA administrator, will then notify the person whose coverage would otherwise end because of such qualifying events that he or she has 60 days to inform Benefits Express of his or her intent to elect COBRA continuation coverage. The qualified beneficiary must elect COBRA continuation coverage following such qualifying events within 60 days of receiving the COBRA Enrollment Notice from Benefits Express. If a qualified beneficiary does not elect COBRA continuation coverage within 60 days of receiving the COBRA Enrollment Notice from Benefits Express, group health plan coverage will end on the date of the qualifying event. (Pay in lieu of Flexible Time Off accrued will not extend your employment or coverage.) To elect continuation of coverage, a qualified person must call Benefits Express at 1-800-758-4460 or enroll on the Your Total Rewards web site. A qualified beneficiary does not have to give evidence of insurability to continue coverage.

Period of COBRA Continuation Coverage
COBRA continuation coverage, if chosen, is identical to Plan coverage provided to similarly situated employees, retirees, or family members. COBRA continuation coverage, if chosen, will begin as of the date of the qualifying event.

If the qualifying event is the retiree’s death, entitlement to Medicare, divorce or legal separation, or a child losing dependent status, COBRA continuation coverage may last for up to 36 months.

If the qualifying event is termination of employment (for other than gross misconduct) or reduction in hours, the COBRA continuation coverage may last for up to 18 months. There are two ways in which this 18-month COBRA continuation coverage can be extended.

First, if a second qualifying event occurs during this 18-month period which would entitle the qualified beneficiary to continue coverage for a longer period (e.g., termination of employment followed by retiree’s death, divorce or legal separation, or a child losing dependent status), coverage may be extended up to 36 months from termination or reduction in hours. The qualified beneficiary must inform Benefits Express at 1-800-758-4460 within 60 days of the second qualifying event. In no event will COBRA continuation coverage last beyond 36 months from the event that originally made the qualified beneficiary eligible to elect COBRA continuation coverage.

Second, the 18-month continuation period may be extended to 29 months for individuals who qualified for COBRA continuation coverage because of termination of employment or reduction in hours and later are determined to be disabled by the Social Security Administration (“SSA”) during the first 60 days of COBRA continuation coverage. This 11-month extension is available provided the individual notifies Benefits Express at 1-800-758-4460 within 60 days after the SSA issued its determination of disability and before the end of the original 18-month COBRA continuation coverage period. You should include a copy of the SSA determination. Non-disabled family members of disabled qualified beneficiaries are also entitled to this extension. The affected individual must also notify Benefits Express at 1-800-758-4460 within 30 days of any final SSA determination that the individual is no longer disabled. You should include a copy of the SSA determination.

Termination of COBRA Continuation Coverage
COBRA continuation coverage may be terminated before the end of the maximum period of COBRA continuation coverage if:
• provision of group medical coverage to retirees ceases,
• the charge for COBRA coverage continuation is not paid when due,
• the qualified beneficiary becomes entitled to Medicare upon the effective date of enrollment in Medicare after electing COBRA continuation coverage,
• the qualified beneficiary becomes covered, after electing COBRA continuation coverage, under another group health plan, unless that plan contains a pre-existing condition exclusion, with respect to any condition that he or she may have. Coverage will continue throughout the pre-existing exclusion period if the required COBRA charge is paid, not to exceed the maximum continuation period,
• the qualified beneficiary extends coverage for up to 29 months based on an SSA determination of disability and there has been a final SSA determination that the individual is no longer disabled, or
• the qualified beneficiary otherwise becomes ineligible under the terms of the Plan.

Cost
In most cases, the charge for continuation of coverage will be 102% of the full cost under the Plan. In cases where the 11-month extension is available based on an SSA determination of disability as described above, the charge for the additional 11 months of COBRA continuation coverage will be increased from 102% to 150% of the full cost under the Plan. There is a grace period of at least 30 days for payment of the regularly scheduled charges.

Trade Act of 2002
Special COBRA rights apply to employees who have been terminated or experienced a reduction in hours and who qualify for trade adjustment assistance under the Federal Trade Act of 1974 (“Eligible Individuals”). Eligible Individuals may be entitled to a second 60-day COBRA election period. The Trade Act of 2002 created a new tax credit under which Eligible Individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA continuation coverage. If you qualify or may qualify for assistance under the Trade Act of 1974, please contact Benefits Express at 1-800-758-4460. You must contact Benefits Express promptly or you may lose our special COBRA rights.

Address Changes, Correspondence and Questions
To protect your family’s rights, you should notify Benefits Express at 1-800-758-4460 about any changes in the addresses of you and your family members. You should keep a copy for your records of any such notices. If you have questions about COBRA continuation coverage, you should contact Benefits Express at the respective address above, or you may contact the nearest Regional or District Office of the US Department of Labor’s Employee Benefits Security Administration (“EBSA”). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA’s website at www.dol.gov/ebsa.

COBRA-Like Continuation Coverage for Domestic Partners
Although there is no legal obligation to offer COBRA continuation rights to covered domestic partners and their children, the Company has elected to provide the opportunity for such persons to continue their health care coverage, if coverage otherwise ends, upon the occurrence of a certain events. Specifically, covered domestic partners and their dependent children generally will be allowed to continue coverage similar to coverage provided to COBRA qualified beneficiaries under the same terms as described above upon the:

• death of a retiree (see "Dependents of Deceased Retirees" below);
• termination of an employee's employment (for other than gross misconduct), or reduction in hours of employment, including retirement, or movement to benefits ineligibility status;
• termination of domestic partnership of the domestic partner from an employee;
• domestic partner’s child loses "dependent" status as defined under the Plan; or
• retiree entitlement to Medicare.

Dependents of Deceased Retirees
Upon the death of a covered retiree, the surviving spouse or domestic partner and dependent children can continue their Plan coverage by paying the annual cost, less the Company’s contribution. This coverage will end on the date a surviving spouse remarries or enters into a domestic partnership, or the domestic partner marries or enters into a new domestic partnership, or, if there is no surviving spouse or domestic partner, the date a dependent child ceases to be a dependent child under the Plan. However, if coverage ends within three years of the retiree’s death, the spouse or domestic partner and/or dependent children may continue their Plan coverage for the balance of the 36-month period by paying the maximum amount allowed by law under COBRA, subject to coverage being canceled earlier, for any of the five reasons listed above under Termination of COBRA Continuation Coverage.

Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA)
Employees and dependents who are eligible but not enrolled for coverage in the Plan may enroll in that coverage under two scenarios:
- The employee’s or dependent’s Medicaid or CHIP (Children’s Health Insurance Program) coverage is terminated as a result of loss of eligibility for such coverage; or
- The employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or CHIP.

If you are eligible under either of the above two scenarios, you must request this special enrollment within 60 days of the loss of coverage in the first scenario, or within 60 days of when eligibility for a premium assistance subsidy is determined in the second scenario. To request the CHIPRA special enrollment, call Benefits Express.

Medicaid and the Children’s Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families
If you are eligible for health coverage, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. For information on eligibility for either of these programs, you can contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply.

Rights of Plan Participants (ERISA)
As a participant in the Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
• Examine, without charge, at the Plan Administrator's office and at other locations all documents governing the Plan including the Plan documents and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
• Obtain copies upon written request to the Plan Administrator of Plan documents governing the operation of the Plan and copies of the latest annual report (Form 5500 Series) and updated Summary Plan Description. The Administrator may make a reasonable charge for the copies.
• Receive a summary of the Health Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.
• Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Health Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Health Plan on the rules governing your COBRA continuation coverage rights, if any. Please note domestic partners and their dependents are not entitled to COBRA continuation coverage under federal law.

In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the plan, have a duty to do so prudently and in the interest of you and other plan participants and beneficiaries. No one, including your employer or any other person, may terminate you or otherwise discriminate against you in any way to prevent you from obtaining benefits or exercising your rights under ERISA.

Under ERISA there are steps you can take to enforce your rights. For example, you may file suit in a federal court if:

• You have a claim for benefits which is denied or ignored, in whole or in part.
• You request materials from the Plan Administrator and do not receive them within 30 days. The court may require the Plan Administrator to provide the materials and pay you up to $110 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.
• The Health Plan fiduciaries misuse the Health Plan's money, or you are discriminated against for asserting your rights. You may also seek assistance from the U.S. Department of Labor.

The court will decide who should pay the court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees; for example, if it finds your claim to be frivolous.

If you have any questions, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

HIPAA Privacy

• The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires, among other things, that health plans protect the confidentiality and privacy of individually identifiable health information and to periodically inform you about:
  • The Health Plan’s uses and disclosures of Protected Health Information (PHI);
  • Your privacy rights and the Health Plan’s duties with respect to your PHI;
  • Your right to file a complaint with the Health Plan and with the Secretary of the U.S. Department of Health and Human Services (HHS); and
  • The person to contact for further information about the Health Plan’s privacy practices.

A description of HIPAA Privacy rights can be found in the Privacy Notice provided to participants covered under the Health Plan. The Health Plan and those administering it will use and disclose health information only as allowed by federal law.

If you have a complaint, question or concern, or require a copy of the Privacy Notice, please contact the Manager, Benefits Administration, Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, MA
This language is intended to satisfy the notice requirements regarding HIPAA Privacy rights with regards to the Health Plan.

HIPAA Portability

A notice of the special enrollment rights under HIPAA must be provided to all participants at the time they are initially offered a chance to enroll in the Plan. To request this notice, contact your claims administrator at the address or telephone number provided at the end of this document.

Administration of the Plan

Interpretation of Plan
The benefit plan Summary Plan Description summarizes the important features of the Health Plan document. While the Summary Plan Description attempts to accurately describe benefits available as of the date of publication, it does not cover every provision of each policy or plan. In the event of a question of interpretation or conflict, the Health Plan document or group insurance policy will govern.

Authority of Plan Administrator
The Plan Administrator, or its designee, has the authority, in its sole discretion, to construe the terms of this Plan and decide all questions of eligibility to participate in the Plan and decide any other matters relating to the administration or operation of the Plan.

Authority of Claims Administrator
For the self-insured plan option, the claims administrators, UnitedHealthcare and SilverScript, have the authority, in its sole discretion, to provide a full and fair review of and to make determinations on first-level and second-level appeals of denied claims under the Health Plan. In making determinations on both first-level and second-level claim appeals, such claim administrators shall act as the appropriate named fiduciary with the discretionary authority to construe the terms of the Health Plan and to determine eligibility for benefits, including the amount, time, and manner of payment of benefits.

Claim and Appeal Procedures

All claims by participants, beneficiaries, and others based on a purported failure to follow the Health Plan's terms, including but not limited to an alleged failure to follow any direction from a participant pursuant to Health Plan terms, an alleged administrative error or omission, or other alleged misconduct, are subject to the Health Plan's claims procedures.

Claim Procedures
The Plan Administrator shall designate a claims administrator for purposes of responding to claims filed in accordance with the claim and appeal procedures below.

You may file claims for medical benefits with the Health Plan claims administrator, UnitedHealthcare. Claims for pharmacy or prescription drug benefits may be filed through SilverScript. You may request a first-level and second level review of an adverse medical claim decision by the Health Plan claims administrator, UnitedHealthcare. Claims may be filed by either yourself or through an authorized representative, who may be a spouse, domestic partner, parent, or designated health care agent. In the case of a claim involving emergency or urgent care, a health care professional with knowledge of your condition may act as your authorized representative.
An urgent care claim is any claim as to which application of the pre-service claim time periods described below could seriously jeopardize your life or health or ability to regain maximum function or would in the opinion of a physician with knowledge of your condition subject you to severe pain that cannot be adequately managed without care or treatment.

**Urgent Care Claims**
If the Claims Administrator or your physician determines that you have an emergency or urgent care claim, you will be notified of the decision not later than 72 hours after the claim is received. If there is not sufficient information to decide the claim, you will be notified of the information necessary to complete the claim as soon as possible, but no later than 24 hours after receipt of the claim. You will be given a reasonable additional amount of time, but not less than 48 hours, to provide the information. You will be notified of the decision not later than 48 hours after the end of that additional time period or after receipt of the information, if earlier. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

**Pre-Service and Post-Service Claims**
If a service, supply, or procedure requires advance approval before a benefit will be payable, this is considered a pre-service claim. You will be notified of the decision not later than 15 days after receipt of the pre-service claim. For other claims - post-service claims - you will be notified of the decision not later than 30 days after receipt of the claim. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

For either a pre-service or a post-service claim, the time periods referenced above may be extended up to an additional 15 days due to circumstances outside the Health Plan’s control. In that case, you will be notified of the extension before the end of the initial 15-day or 30-day period. If the extension is necessary because of failure to submit sufficient information, you will be notified of the specific information necessary and given an additional period of at least 45 days to furnish that information. In such case, the decision-making period is tolled or suspended from the date the extension notice is sent until the earlier of the date the additional information is received or the end of the 45-day period. You will be notified of the claim decision no later than 15 days after the end of that additional 45-day period or after receipt of the information, if earlier.

If you do not follow the pre-service claim procedures, you will be notified of the failure and the proper procedures no later than 5 days following the failure or within 24 hours for emergency or urgent care claim. The notice may be oral unless you request written notice.

**Concurrent Care: Ongoing Course of Treatment**
If you are receiving an ongoing course of treatment, you will be notified in advance if the Claims Administrator intends to terminate or reduce benefits for the course of treatment so that you will have an opportunity to appeal the decision before the termination or reduction takes effect. If the course of treatment involves emergency or urgent care, and you request an extension of the course of treatment at least 24 hours before its expiration, you will be notified of the decision within 24 hours after receipt of the request. The time frames described above begin at the time a claim is filed, without regard to whether all the information necessary to make a decision accompanies the filing.

**Claim Denial Letters**
If your claim is denied in whole or in part, you will receive a written notice of the denial. The denial letter will contain:

(a) the specific reason for the denial;
(b) reference to specific provisions on which the decision is based;
(c) a description of any additional information necessary to perfect the claim and the reason why such information is necessary;
(d) a description of the appeal procedures and time frames, including a statement of the right to bring a civil action under ERISA following an adverse decision on review;

(e) if applicable, the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request; and

(f) if the decision was based on a “medical necessity” or “experimental treatment” or similar exclusion or limit, either an explanation of the scientific or clinical judgment for the determination, or a statement that such explanation will be provided free upon request.

Appeal Procedures with respect to claim denials by UnitedHealthcare
First Level Review Appeal Time Periods
If you wish to appeal an adverse benefit decision of a decision by UnitedHealthcare, you must do so in writing to the Health Plan claims administrator, at the address noted on your identification card, within 180 days of the adverse benefit decision. You will be notified of the decision not later than 15 days (for pre-service claims) or 30 days (for post-service claims) after the appeal is received.

Second Level Review Appeal Time Periods
You must within 60 days following receipt of an adverse first level appeal decision by UnitedHealthcare, submit a second level appeal in writing to the Health Plan claims administrator at the address on your identification card. You will be notified of the decision by the Health Plan claims administrator not later than 15 days (for pre-service claims) and 30 days (for post-service claims) after the second level appeal is received.

The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

If the claim involves emergency or urgent care, you or your authorized representative may appeal the denial either orally or in writing to the Health Plan claims administrator. All necessary information, including the appeal decision, will be communicated between you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

The appeal time periods described above begin at the time an appeal is filed, without regard to whether all the information necessary to make a decision on appeal accompanies the filing.

Appeal Procedures with respect to claim denials by SilverScript
Appeal Time Periods
If you wish to appeal an adverse benefit decision by SilverScript, you must do so in writing or via phone to SilverScript, at the phone number noted on your identification card, within 60 days of the adverse benefit decision. You will be notified of the decision, assuming one level of review, not later than 7 days (for pre-service claims) and 30 days (for post-service claims) after the appeal is received.

If the claim involves emergency or urgent care, you or your authorized representative may appeal the denial either orally or in writing to SilverScript. All necessary information, including the appeal decision, will be communicated between you or your authorized representative by telephone, facsimile, or other similar method. You will be notified of the decision not later than 72 hours after the appeal is received.

Appeal Rights
You may submit, and have a right to an appeal review that takes into account, written comments, documents, records, and other information relating to the claim, whether or not such information was submitted or considered in the initial decision. You may request, free of charge, copies of all documents, records, and other information relevant to your claim. You have a right to an appeal review that does not afford deference to the initial denial, and that is conducted by a person who is neither the individual who made the initial denial, nor
that person’s subordinate. The Plan Administrator, in deciding an appeal based on a medical judgment, must consult a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment, and who was neither consulted in connection with the denial, nor is the subordinate of any health care professional consulted during the initial claim review. You have a right to the identification of medical or vocational experts consulted in connection with a claim denial, without regard to whether the advice was relied upon in making the decision.

Appeal Denial Letter
The appeal denial letter will contain:

(a) the specific reasons for the adverse decision on appeal;

(b) reference to specific provisions on which the decision is based;

(c) if applicable, the specific rule, guideline, protocol, or other similar criterion relied upon in making the decision, or a statement that such rule, guideline, protocol, or criterion will be provided free upon request.

Legal Proceedings
You will not be entitled to challenge a claim decision made by the Claims Administrator in federal or state court or in any other administrative proceeding until all of the Claim and Appeal procedures outlined above have been complied with and exhausted: No lawsuit shall be brought against the Plan, the Plan Sponsor, the Company, the Plan Administrator or the Claims Administrator by you or your authorized representative until:

- 60 days after Proof of claim has been given; and
- no more than three years after the time Proof of claim is required.

Amendment or Termination of the Plan
The Company can adopt any amendment to the Plan or terminate the Plan at any time. Any action that may be taken by the Company to amend or terminate the Plan may also be taken by the Company’s Chief Executive Officer except as otherwise restricted under the Company’s Compensation Committee charter.

General Provisions
The Health Plan is a group health plan. Health Plan records are maintained on a calendar-year basis: January 1st through December 31st.

The Plan Sponsor is the Liberty Mutual Group Inc. The employer identification number assigned by the Internal Revenue Service to Liberty Mutual Group Inc. is 04-3583679. The plan number assigned in accordance with instructions of the Internal Revenue Service is 503.

The Health Plan offers participation to employees and retirees of the Company and its subsidiaries that participate in the Health Plan including Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116. A list of participating subsidiaries is available on request.

Benefits are paid out of the Company’s general assets. The Health Plan is unfunded. Costs of coverage are shared by the Company and employees.
Retiree contributions are made on an after-tax basis. The Company has contracted with UnitedHealthcare to provide administrative services. Claims administrator addresses are listed at the end of this document.

For purposes of ERISA and the Health Plan, Liberty Mutual Insurance Company is the Plan Administrator. Your rights under ERISA are described above. Melanie M. Foley, Executive Vice President, Chief Talent and Enterprise Services Officer is designated as agent for service of legal process for the Plan Administrator. Process may be served on her at Liberty Mutual Insurance Company, 175 Berkeley Street, Boston, Massachusetts 02116, Attention: Benefits Department – Mailstop M03E.

**Claims Administrators**

The following is a list of claims administrators:

- UnitedHealthcare, 185 Asylum Street, Hartford, CT 06103; 1-844-LIB-MUT4 (1-844-542-6884)
- SilverScript Insurance Company, P.O. Box 52067, Phoenix, AZ 85072-2067 (1-888-644-0334)