Minuteman Health

EMPLOYER CONTRACT

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Coverage under this Plan is under the jurisdiction of the New Hampshire Insurance Commissioner. MHI is in "Good Standing" with the State of New Hampshire.

IMPORTANT INFORMATION: This policy reflects the known requirements for compliance under The Affordable Care Act as passed on March 23, 2010. As additional guidance is forthcoming from the US Department of Health and Human Services and the New Hampshire Insurance Department, those changes will be incorporated into your health insurance policy.

EMPLOYER GROUP AGREEMENT

This Employer Group Agreement (the "Agreement") is between Minuteman Health, Inc. ("MHI") and _ (the "Employer") regarding the provision of administrative

services by MHI and the obligations of the Employer under the health benefits plan (the "Plan") established by the Employer.

WHEREAS, MHI is a Consumer Operated and Oriented Plan Program (CO-OP) as that term is defined in, and subject to the requirements established by, or under the authority of, Section 1322 of the Patient Protection and Affordable Care Act of 2010; and

WHEREAS, MHI is licensed in the state of New Hampshire as a health maintenance organization ("HMO") under RSA 420-B, and

WHEREAS, MHI provides administrative, claims processing, and related services for health care delivery and reimbursement plans.

WHEREAS, the Employer is a business entity which has established the Plan described in the applicable Membership Agreement or Evidence of Coverage ("EOC") which is incorporated herein by reference.

NOW, THEREFORE, in consideration of the mutual promises and agreements set out herein, MHI and the Employer agree as follows:

I. DEFINITIONS

Except as otherwise provided herein, the definitions set forth in the applicable MHI Membership Agreement or EOC are specifically incorporated into this Agreement.

II. EMPLOYER GROUP APPLICATION

The Employer's MHI Employer Group Application is incorporated into this Agreement by reference.

III. ELIGIBILITY

A. Only bona fide employees and retirees of the Employer and their qualified dependents may be enrolled in the Plan, unless otherwise required by the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA") or other applicable law.

B. To be eligible for enrollment, and continuing participation, in the Plan, all employees and their dependents must meet the eligibility rules for the Plan which are set out in the applicable Membership Agreement, Underwriting Guidelines, and EOC. If the Employer wishes to modify these eligibility rules, such modification must be indicated on the Employer Group Application or in a written amendment thereto, which modification must be accepted in writing by MHI. The eligibility rules will not be changed during the term of the Agreement except by mutual written consent of the parties. MHI will implement these eligibility rules.

C. MHI is not responsible for verifying the eligibility status of employees or dependents, and will rely on information provided to it by the Employer. Employer is obligated to use best efforts to ensure that it obtains all information required to determine whether individuals covered under the Employer's plan are eligible. Employer will immediately inform MHI of any person who is either applying for Membership or who is already enrolled as a Member that may be ineligible. In the event that the Employer fails to provide such information to MHI, the Employer shall reimburse, indemnify, and hold harmless MHI for any expenses that MHI incurs as a result of the Employer failing to provide such information to MHI.

D. MHI may terminate a Member, prospectively or retroactively, who fails to meet the eligibility rules of the Plan.

E. Employer represents that, to the best of Employer's knowledge and belief based on reasonable inquiry and due diligence, the information contained in the Membership Application is true and correct. This shall be an ongoing representation throughout the term of this Agreement.

IV. MEMBER VERIFICATION

A. Upon request, the Employer shall provide MHI with any documents or records (including without limitation payroll records, documentation of residence, marital status, birth or adoption, documentation of pediatric dental coverage, and legal responsibility for health insurance coverage) reasonably necessary to verify Member eligibility, Employer contributions, or any other issues related to the services provided under this Agreement. MHI shall maintain the confidentiality of such records unless otherwise required to disclose such records by law.

V. ENROLLMENT

A. An initial MHI open enrollment period shall take place prior to the effective date of this Agreement or other date agreed upon by MHI and the Employer.

B. An annual open enrollment period shall be held prior to the Employer's Annual Anniversary date of this Agreement or such other date agreed to by MHI and Employer.

C. During an enrollment period the Employer shall distribute information about MHI. The Employer will review with MHI any communication regarding MHI prior to its distribution to employees.

D. For Members enrolling outside the open enrollment period, MHI must receive proper notice from the Employer of any Member enrollment in the Plan at least fifteen (15) days prior to the requested effective date. MHI may, upon request, and in its sole discretion, which may be withheld for any reason, retroactively enroll a Member. However, in no event shall a Member's effective date be retroactive more than sixty (60) days prior to the date MHI received the Employer's notice.

E. MHI must receive proper notice from the Employer of any Member terminations from the Plan no more than sixty (60) days after such change is to be effective. Any request for the termination of a Member as of a date earlier than sixty (60) days prior to receipt by MHI will be processed by MHI as effective sixty (60) days retroactive from the date of receipt.

VI. PAYMENTS

A. Monthly Premiums:

1. During the initial term of this Agreement, the monthly premium shall be the amount stated in the Employer Group Application or the current rate notice given under section VII.B, below. In subsequent years, the amounts will be determined as described in Section IX.

2. An Employer's effective date will be set on the first day of a month. However, MHI may allow, in its sole discretion, an Employer to enroll with an effective date other than the first of the month. In these cases, the Employer's premium for its first month of coverage will be prorated based on the Employer's effective date.

3. For groups with an initial effective date on or after January 1, 2015, MHI will charge the Employer for Members who enroll or terminate other than on the first day of the month on a prorated basis.

4. Prior to each month of coverage, MHI shall bill the Employer an amount equal to the Monthly Premium based on the Employer's enrollment as of the first day of the month in which the bill is sent plus any amounts past due. If additions, deletions, or other Membership changes are made after the bill is sent, they will be reflected by an appropriate adjustment in a subsequent bill.

5. The Employer shall pay the premium bill prior to the first day of each month of coverage. In the event that Employer has not received an invoice from MHI, Employer is still obligated to pay, at a minimum, the previous month's premium bill amount. If any portion of the premium remains unpaid as of the first day of any given month, MHI may terminate this Agreement and all benefits to Members, in accordance with Section VII.C, including the applicable grace periods as set forth in that Section VII.C. MHI's decision not to terminate shall not operate as a waiver to terminate at any time prior to all outstanding premiums being paid.

6. At MHI's sole discretion, any payment of premium by the Employer may be allocated to payment of past due premiums under this Agreement in the order incurred.

7. The Employer shall pay MHI any and all taxes resulting from MHI's administering of services, including, but not limited to, premium taxes, and MHI shall have the right to collect such taxes on a monthly basis.

8. In the event payment in full is not received and the collection of the unpaid balance is assigned to a credit collection service, the Employer will pay all related collection and legal fees incurred related to the collection of the unpaid balance.

B. **Rate Changes:**

MHI may change the premium rates due under this Agreement sixty (60) days in advance of the Anniversary Date specified in the Employer Group Application.

C. Copayments, Coinsurance, Deductibles and Balances Due: Any copayments, coinsurance, deductibles and balances due for services provided to a Member will be collected directly from the Member by the provider.

D. Employer Contribution: The Employer shall contribute at least fifty percent (50%) of the premium for the Individual Coverage or at least thirty-three (33%) of the premium for Family Coverage applicable to each Subscriber. Any changes in the Employer contribution must be mutually agreed to in writing.

VII. TERM AND TERMINATION

A. **Term**: The initial term of this Agreement is stated on the Employer Group Application. This Agreement shall continue in force and effect from year to year thereafter, without the requirement that a new agreement be signed, unless sooner terminated in accordance with this Agreement, or unless not renewed as provided for in Section IX.

B. **Termination by the Employer**: The Employer may terminate this Agreement without cause at any time by advanced written notice. The specific termination date will be the last day of the month in which the notice was given. Termination will be effective as of midnight of the date specified in the notice and premium payments prorated to reflect payment through the end of the termination date must be paid in full. All coverage and benefits for all employees and dependents under this Agreement shall terminate as of the specified termination date.

C. **Termination for Nonpayment of Premiums:**

1. **For Agreements purchase through the FF SHOP**: If premium payment is not received 31 days from the first of the coverage month, the FF-SHOP may terminate the Employer for lack of payment. If the Employer is terminated due to lack of premium payment, but within 30 days following its termination the Employer requests reinstatement, pays all premiums owed including any prior premiums owed for coverage during the grace period, and pays the premium for the next month's coverage, the FF-SHOP must reinstate the qualified employer in its previous coverage. A group may only be reinstated once per year.

2. **For Agreements purchased outside of the FF SHOP**: The Employer will have a thirty-one (31) day grace period beginning on the invoice due date to pay the premium or other balances. Coverage will remain in effect during the 31-day grace period. The effective date of termination will be determined by MHI. Termination may be retroactive to the extent permitted by applicable law. MHI will notify Members of the Employer as to the termination date and the reason for termination. In such event, notice of termination will be sent to Members as required by law. In the event of termination due to nonpayment of premiums, the Employer shall remain liable to MHI for premiums due through and including the date of termination in addition to any other remedies to which MHI may be entitled.

D. **Termination for Cause**: MHI may terminate this Agreement for cause for the following:

1. on the day following the last day of the Grace Period, if premium or other amounts due remain unpaid;
2. fraud or intentional misrepresentation subject to RSA 415:18 I(r) which states that the validity of the policy shall not be contested except for nonpayment of premiums, after it has been in force for 2 years from its date of issue; and that no statement made by any person covered under the policy relating to insurability shall be used in contesting the validity of the insurance with respect to which such statement was made after such insurance has been in force prior to the contest for a period of 2 years during such person's lifetime, nor unless it is contained in a written instrument signed by the person making such statement;
3. violation of minimum participation or contribution rules and/or failure to provide information sufficient to confirm compliance with participation or contribution rules;
4. movement of all enrollees outside the MHI service area;
5. discontinuation or termination of the Plan;
6. as of the date Employer's membership in a US Department of Labor approved Qualified Associated Trust as defined by RSA 420-G:2 or in an ERISA-qualified Taft-Hartley union ceases.

In the event of termination for cause, the Employer shall remain liable to MHI for premiums due through and including the date of termination in addition to any other remedies to which MHI may be entitled.

VIII. RENEWAL OF THIS AGREEMENT; AMENDMENTS

A. **Renewal**:

1. At least sixty (60) days prior to the end of the initial term of this Agreement, and at least sixty (60) days before each renewal date thereafter, MHI shall either inform the Employer that it does not intend to renew this Agreement or inform the Employer of the projected premiums for the renewal term. MHI also will describe any proposed amendments or benefit changes for the renewal term.

2. MHI may decline to renew this Agreement for any of the following reasons:

   a. Nonpayment of required premiums

   b. Fraud or intentional misrepresentation on the part of an employer or Plan Sponsor.

   c. Failure to meet the minimum employee participation number or percentage requirement of the health coverage.

   d. The small employer is no longer actively engaged in the business that it was engaged in on the effective date of the health coverage.

   e. The Employer medically underwrites or otherwise violates the provisions of RSA 420-G:6

   f. MHI ceases to offers health coverage in the market after providing 180 days notice to the Group, enrollees and the Commissioner of Insurance.

3. Notwithstanding Section VII.B, if the Employer desires not to renew this Agreement for the succeeding year, it shall notify MHI in writing at least fifteen (15) days before the renewal date.

4. Payment by the Employer to MHI or the acceptance of benefits under this Agreement after the renewal date shall be deemed to constitute acceptance of continuing this Agreement for the succeeding one-year term and acceptance of any and all amendments as allowed by state and federal law, rate and benefit changes proposed by MHI.

B. **Amendments**: Except as set forth herein, no alteration or modification of the terms and conditions of this Agreement shall be valid or of any force or effect unless it is expressed in a written amendment duly executed by the parties.

IX. HEALTH CARE SERVICES ADMINISTRATION

A. **Obligation to Administer Plan Benefits**:

1. In consideration of the agreed periodic payments specified in the Employer Group Application, MHI shall administer the Plan in accordance with the terms and conditions of the applicable Membership Agreement or EOC. Except for the Employer's obligation to pay monthly premiums, neither MHI nor its participating providers shall bill or charge the Employer for any benefits to which Members may be entitled under the Plan.

2. MHI is obligated to administer the Plan described in the applicable Membership Agreement or EOC only for the period for which the applicable premium has been paid.

3. MHI may be required to change the terms of the applicable Membership Agreement or EOC by state or federal law. MHI shall give the Employer, when possible, at least sixty (60) days notice prior to the effective date of any change. Any such amendment will be effective for benefits or services provided after the effective date of the change.

4. This Agreement is not intended, nor shall it be construed, to affect any provider-patient relationship. The Employer acknowledges that MHI does not practice medicine or any other profession, or control the provision of covered services to Members. The Employer acknowledges that MHI does not employ or control any care and treatment decisions made by any health care providers that will provide health care benefits to Members. Both the Employer and MHI acknowledge that it is the attending health care provider who is exclusively responsible for the care and treatment of the Members under such provider's care.

5. The Employer acknowledges that physicians and providers in the MHI network are independent contractors and the composition of the network is likely to change from time to time. MHI cannot guarantee the continued participation of specific physicians or providers in its network.

B. **Subrogation and Coordination of Benefits**: MHI coverage is subject to the rules for coordination of benefits and subrogation described in the applicable Membership Agreement or EOC; the Coordination of Benefits and Subrogation section of the EOC is attached at Exhibit A for reference. MHI coordinates benefits with other insurers that may be liable for benefits to Members. The Employer agrees to cooperate with MHI in obtaining information concerning the potential liability of a third party for the cost of a Member's care, including, but not limited to, other insurance coverage available to Members. In the event that the Employer fails to cooperate with MHI consistent with this section, the Employer shall reimburse, indemnify, and hold harmless MHI for any expenses that MHI incurs as a result of said failure.

C. **HIPAA and COBRA Administration**: MHI neither will be responsible for nor assume any of the Employer's responsibilities under the Health Insurance Portability and Accountability Act ("HIPAA") or COBRA unless MHI agrees to do so in a separate agreement that sets forth each party's responsibilities in detail.

X. AGREEMENT BINDING ON MEMBERS

The Employer represents that, to the best of Employer's knowledge and belief based on reasonable inquiry and due diligence, all Members enrolling in Employer's Plan are and shall remain in compliance with all terms, conditions and provisions set out in the applicable Membership Agreement or EOC. The Subscribers shall be responsible for the compliance with the terms and conditions of the Membership Agreement or EOC by their dependents; minor dependents of employees will be bound by the action of the employee.

XI. CONFIDENTIALITY OF MEMBER INFORMATION

A. The Employer understands and acknowledges that MHI will only release *non-confidential* member information to Employer if the Employer requests such information, in writing, for purposes such as billing, enrollment or eligibility verification. For purposes of this Section XI.A., Non-confidential member information shall consist only of names, addresses and ages of enrolled subscribers and their dependents. No other information shall be released to employers, including brokers, agents and consultants for employers, unless the Employer obtains a specific consent from the Member or unless the Employer is auditing the Plan in accordance with subsection B of this section.

B. Employer must give MHI thirty (30) days prior written notice of its intent to audit and provide a detailed narrative explaining the need for such information. All audits and information disclosure shall occur at a time and place and in a manner convenient to MHI and shall be conducted at Employer's expense. Any representative of the Employer engaged in such audit shall agree to use any disclosed information solely for the purposes of administering the Plan, to keep such information confidential and not to disclose the information to any other entity or person.

C. MHI may release aggregate data to an employer, as long as the information is encrypted or de-identified so that all information that clearly identifies a member, or that could be used to identify a member, has been removed.

D. Any reports, information or documentation provided, made available, or learned by either of the parties to this Agreement which contain personally identifiable or health information about any Member or health care provider or which contain information about either party's business or operations which is not available to the public, or which contain information which has been designated

as proprietary or confidential by either party shall be held in strictest confidence, used solely to perform the obligations under this Agreement or to administer the Plan, not be disclosed to any other entity or person, and maintained in accordance with the requirements of all applicable laws.

XII. RESOLUTION OF DISPUTES

A. **Member Appeals**: All Member appeals shall be resolved in accordance with the provisions of the applicable Membership Agreement or EOC.

XIII. LIMITATION ON ACTION

No action at law or in equity shall be brought to recover on the policy prior to the expiration of sixty (60) days after proof of loss has been filed in accordance with the requirements of the policy and that no such action shall be brought at all unless brought within 2 years from the expiration of the time within which proof of loss is required by the policy.

XIV. CONFLICT OF LAWS

This Agreement shall be governed by the laws of the state of New Hampshire.

XV. NOTICE

Unless otherwise specified, any notice required under this Agreement shall be in writing delivered by any of the following methods: (i) by a national express mail order (notice deemed delivered upon receipt); (ii) by first class mail (notice deemed delivered three (3) business days from mailing); or (iii) by certified mail, postage prepaid (notice deemed delivered upon receipt). All notices shall be provided to the address shown on the Employer Group Application, unless otherwise notified in writing of an alternative address.

XVI. INVALID PROVISIONS

If, for any reason, any provision of this Agreement shall be, or is hereafter determined to be invalid, such determination shall not nullify any of the other terms and provisions of this Agreement, and in such respects as may be necessary to conform this Agreement with the applicable provisions of law in order to prevent the invalidity of such provision, then such provision shall be deemed automatically amended to conform with such law.

XVII. CAPTIONS

The captions in this Agreement are inserted for convenience and reference, and in no way define, describe or limit the scope or intent of this Agreement or any of the provisions hereof

XVIII. MISCELLANEOUS

A. **Amendments**

1. By MHI. MHI may amend this Agreement when required by state or federal law, without consent of the Employer, by providing (30) days prior notice to the Employer. Amendments will take effect on the date specified in the notice

unless the Employer notifies MHI in writing at least (10) days before the proposed change takes effect that the Employer is terminating the Agreement. Except as specified in Section VI(B) above, MHI may change the premium rates only effective on each Contract Anniversary Date. The amended premium rate will be confirmed in a rate letter from MHI to the Employer, which will automatically amend this Agreement and be incorporated herein by reference. The Employer shall be solely responsible for providing notice to members of these amendments, and MHI shall not be responsible for any consequences of the Employer's failure to provide such notice.

2. By the Group. The Group must provide to MHI thirty (30) days prior written notice of any amendment of this Agreement proposed by the Group. Such amendment shall be effective only if MHI has accepted such proposed amendment in writing, which acceptance may be withheld by MHI in its sole and absolute discretion.

B. **Force Majeure**. If, in the event of circumstances beyond the control of MHI, including but not limited to an act of God, riot, natural disaster, epidemic, public emergency, strike, war, civil insurrection, the complete or partial destruction of facilities of MHI or its providers of services, or the disability of their personnel, delays or renders MHI unable to arrange for the services set forth in this Agreement, MHI shall incur no liability or obligation for the delay, or failure to arrange for such services. In such event, MHI shall refund a pro rata amount of the prepaid subscription rate to the Employer for the period in which it was unable or to arrange for benefits set forth in this Agreement.

C. **Entire Agreement**. This Agreement, the Employer Group Application, the enrollment applications submitted by all the Subscribers on behalf of themselves and their enrolled Dependents together with any attachments, rate letters, riders or endorsements, constitute the entire contract, agreement and understanding between MHI and the Employer and supersedes all other prior oral or written agreements. Any change or waiver to this Agreement shall be effective only if evidenced by a written amendment to this Agreement signed by an authorized officer of MHI. Failure to insist on strict performance of any provision of this Agreement shall not constitute a waiver of such provision. The waiver of a provision of this Agreement on any one occasion shall not be deemed a waiver of any other provision of this Agreement, or as a waiver of such provision on any subsequent occasion.

D. **Successors.** This Agreement may not be assigned by one party without the other's written consent, except that MHI may assign this Agreement to any affiliate of MHI or to another qualified insurer as a result of a strategic transaction between MHI and that insurer. This Agreement shall inure to the benefit of and be binding upon the Group and MHI, and their respective successors and permitted assigns.

E. **Relationship of the Parties**. MHI is not engaged in the practice of medicine. Rather, MHI provides health insurance services, makes decision regarding coverage of services, and contracts with health care providers to participate in the MHI network. Providers in the MHI network exercise their own

independent medical judgment regarding the treatment of their patients, regardless of MHI's coverage decisions. MHI does not have control over, and shall not be liable for, the way that providers perform work or render services, including any acts, omissions, representations or other conduct of any provider. Each provider is solely responsible for all Health Care Services that they furnish to Members, and neither party shall have the express or implied right of authority to assume or create any obligation on behalf of, or in the name of the other party through its actions, provisions, or regulations.

F. **Indemnification**. The Employer agrees to indemnify and hold MHI harmless from and against all claims, losses, damages, costs or expenses, including reasonable attorneys' fees, arising out of the Employer's failure in the performance of its duties and obligations under this Agreement.

G. The Employer shall notify MHI immediately of (i) any actual or suspected fraud, waste, or abuse, (ii) any unauthorized acquisition or disclosure of confidential information (including but not limited to personal health information, personal information, and/or Minuteman's confidential business information), and/or (iii) any other legal or compliance related matter in any way relating to or arising out of the good or services provided pursuant to this Agreement. The Employer can contact MHI directly, or provide anonymous information by calling the Minuteman Compliance Hotline at 855-400-0098.

Executed as a sealed instrument this_____day of_____, 20_____.

Employer
Name:_____

Contact Name
(print):_____

Signature:_____

Title:_____

Address:_____

Minuteman Health, Inc.

By: _____

Name:_____(print)

Name:_____(signature)

Title:_____

Exhibit A

Coordination of Benefits and Subrogation

The Coordination of Benefits (COB) provision applies when a person has health care coverage under more than one Plan. Plan is defined below.

The order of benefit determination rules governs the order in which each Plan will pay a claim for benefits. The Plan that pays first is called the Primary plan. The Primary plan must pay benefits in accordance with its policy terms without regard to the possibility that another Plan may cover some expenses. The Plan that pays after the Primary plan is the Secondary plan. The Secondary plan may reduce the benefits it pays so that payments from all Plans does not exceed 100% of the total Allowable expense.

DEFINITIONS

For the purposes of this section detailing COB, the following terms are used as follows:

(a) A Plan is any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

(1) Plan includes: group and non-group insurance contracts, health maintenance organization (HMO) contracts, closed panel plans or other forms of group or group-type coverage (whether insured or uninsured); medical care components of long-term care contracts, such as skilled nursing care; medical benefits under "no-fault "or "personal injury protection "(PIP) automobile contracts; and Medicare or any other federal governmental plan, as permitted by law.

(2) Plan does not include: hospital indemnity coverage or other fixed indemnity coverage; accident only coverage; specified disease or specified accident coverage; limited benefit health coverage, as defined by state law; school accident type coverage; medical payments coverage in a personal automobile policy, also known as Part B or med pay coverage; benefits for non-medical components of long-term care policies; Medicare supplement policies; Medicaid policies; or coverage under other federal governmental plans, unless permitted by law.

Each contract for coverage under (1) or (2) is a separate Plan. If a Plan has two parts and COB rules apply only to one of the 2, each of the parts is treated as a separate Plan.

(b) This plan means, in a COB provision, the part of the contract providing the health care benefits to which the COB provision applies and which may be reduced because of the benefits to other plans. Any other part of the contract providing health care benefits is separate from this plan. A contract may apply one COB provision to certain benefits, such as dental benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

(c) The order of benefit determination rules determines whether This plan is a Primary plan or Secondary plan when the person has health care coverage under more than one plan. When This plan is primary, it determines payment for its benefits first before those of any other Plan without considering any other Plan's benefits. When This plan is secondary, it determines its benefits after those of another Plan and may reduce the benefits it pays so that all Plan benefits do not exceed 100% of the total Allowable expense.

(d) Allowable expense is a health care expense, including deductibles, coinsurance and copayments, that is covered at least in part by a Plan covering the person. When a Plan provides benefits in the form of services, the reasonable cash value of each service will be considered an Allowable expense and a benefit paid. An expense that is not covered by any Plan covering the person is not an Allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a covered person is not an Allowable expense.

The following are examples of expenses that are not Allowable expenses:

(1) The difference between the cost of a semi-private hospital room and a private hospital room is not an Allowable expense, unless one of the Plans provides coverage for private hospital room expenses.

(2) If a person is covered by 2 or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology, any amount in excess of the highest reimbursement amount for a specific benefit is not an Allowable expense.

(3) If a person is covered by 2 or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary plan's payment arrangement shall be the Allowable expense for all Plans. However, if the provider has contracted with the Secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the Primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable expense used by the Secondary plan to determine its benefits.

(5) The amount of any benefit reduction by the Primary plan because a covered person has failed to comply with the Plan provisions is not an Allowable expense. Examples of these types of plan provisions include second surgical opinions, precertification of admissions, and preferred provider arrangements.

(e) Closed panel plan is a Plan that provides health care benefits to covered persons primarily in the form of services through a panel or providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by a panel member.

(f) Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

ORDER OF BENEFIT DETERMINATION RULES

When a person is covered by 2 or more Plans, the rules for determining the order of benefit payments are as follows:

(a) The Primary plan pays or provides its benefits according to its terms of coverage and without regard to the benefits under any other Plan.

(b) Except as provided in paragraph (2),

(1) A Plan that does not contain a coordination of benefits provision that is consistent with this rule is always primary unless the provisions of both Plans state that the complying plan is primary.

(2) Coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits and provides that this supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan hospital and surgical benefits, and insurance type coverages that are written in connection with a Closed panel plan to provide out-of-network benefits.

(c) A Plan may consider the benefits paid or provided by another Plan in calculating payment of its benefits only when it is secondary to that other Plan.

(d) Each Plan determines its order of benefits using the first of the following rules that apply:

(1) Non-Dependent or Dependent. The Plan that covers the person other than as a dependent, for example as an employee, member, policyholder, subscriber or retiree is the Primary plan and the Plan that covers the person as a dependent is the Secondary plan. However, if the person is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the Plan covering the person as a dependent; and primary to the Plan covering the person as other than a dependent (e.g. a retired employee); then the order of benefits between the 2 Plans is reversed so that the Plan covering the person as an employee, member, policyholder, subscriber or retiree is the Secondary plan and the other Plan is the Primary plan.

(2) Dependent Child Covered Under More Than One Plan. Unless there is a court decree stating otherwise, when a dependent child is covered by more than one Plan the order of benefits is determined as follows:

a. For a dependent child whose parents are married or are living together, whether or not they have ever been married:

1. The Plan of the parent whose birthday falls earlier in the calendar year is the Primary plan; or

2. If both parents have the same birthday, the Plan that has covered the parent the longest is the Primary plan.

b. For a dependent child whose parents are divorced or separated or not living together, whether or not they have ever been married:

1. If a court decree states that one of the parents is responsible for the dependent child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree;

2. If a court decree states that both parents are responsible for the dependent child's health care expenses or health care coverage, the provisions of subparagraph (a) above shall determine the order of benefits;

3. If a court decree states that the parents have joint custody without specifying that one parent has responsibility for the health care expenses or health care coverage of the dependent child, the provisions of subparagraph (a) above shall determine the order of benefits; or

4. If there is no court decree allocating responsibility for the dependent child's health care expenses or health care coverage, the order of benefits for the child are as follows:

The Plan covering the Custodial parent;
The Plan covering the spouse of the Custodial parent;
The Plan covering the non-custodial parent; and then
The Plan covering the spouse of the non-custodial parent.

c. For a dependent child covered under more than one Plan of individuals who are the parents of the child, the provisions of subparagraph (a) or (b) above shall determine the order of benefits as if those individuals were the parents of the child.

(3) Active Employee or Retired or Laid-off Employee. The Plan that covers a person as an active employee, that is, an employee who is neither laid off nor retired, is the Primary plan. The Plan covering that same person as a retired or laid-off employee is the Secondary plan. The same would hold true if a person is a dependent of an active employee and that same person is a dependent of a retired or laid-off employee. If the other Plan does not have this rule, and as a result, the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (d) (1) can determine the order of benefits.

(4) COBRA or State Continuation Coverage. If a person whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan cover the person as an employee, member, subscriber or retiree covering the person as a dependent of an employee, member, subscriber or retiree is the Primary plan and the COBRA or state or other federal continuation coverage is the Secondary plan. If the other Plan does not have this rule, and as a result the Plans do not agree on the order of benefits, this rule is ignored. This rule does not apply if the rule labeled (d)(1) can determine the order of benefits.

(5) Longer or Shorter Length of Coverage. The Plan that covered the person as an employee, member, policyholder, subscriber or retiree longer is the Primary plan and the Plan that covered the person the shorter period of time is the Secondary plan.

(6) If the preceding rules do not determine the order of benefits, the Allowable expenses shall be shared equally between the Plans meeting the definition of Plan. In addition, this plan will not pay more than it would have paid had it been the Primary plan.

EFFECT ON THE BENEFITS OF THIS PLAN

(a) When This plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable expenses. In determining the amount to be paid for any claim, the Secondary plan will calculate the benefits it would have paid in the absence of other health care coverage and apply that calculated amount to any Allowable expense under its Plan that is unpaid by the Primary plan. The Secondary plan m a y then reduce its payment by the amount so that, when combined with the amount paid by the Primary plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable expense for that claim. In addition, the Secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

(b) If a covered person is enrolled in two or more Closed panel plans and if, for any reason, including the provision of service by a non-panel provider, benefits are not payable by one Closed panel plan, COB shall not apply between that Plan and other Closed panel plans.

RIGHT TO RECEIVE AND RELEASE NEEDED INFORMATION

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under This plan and other Plans. Please note that MHI uses Health New England Advisors (HNE) to administer COB. HNE may get the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under This plan and other Plans covering the person claiming benefits. HNE need not tell, or get the consent of, any person to do this. Each person claiming benefits under This plan must give HNE any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

A payment made under another Plan may include an amount that should have been paid under This plan. If it does, HNE may pay that amount to the organization that made that payment. That amount will then be treated as though it were a benefit paid under This plan. HNE will not have to pay that amount again. The term "payment made "includes providing benefits in the form of service, in which case "payment made "means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of the payments made by HNE is more than it should have paid under this COB provision, it may recover the excess from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the covered person. The "amount of the payments made "includes the reasonable cash value of any benefits provided in the form of services.