TOWN OF NORTHBOROUGH
HEALTH REIMBURSEMENT ARRANGEMENT
SUMMARY PLAN DESCRIPTION

This is merely a summary of the main features of the Plan and not a detailed description of all of its provisions. If, in the future, the provisions described herein should change for any reason, the Plan Administrator will provide you with a summary of the changes.

IF, FOR ANY REASON, THERE IS AN OMISSION OR MISSTATEMENT IN THIS SUMMARY, OR ANY DIFFERENCE BETWEEN THIS SUMMARY AND THE PLAN DOCUMENT, THE PLAN DOCUMENT WILL IN ALL RESPECTS CONTROL AND GOVERN.

Dear Employee and or Retiree:

The Town of Northborough is pleased to provide you with a health reimbursement arrangement (an "HRA"), which is designed to reimburse certain Eligible Medical Care Expenses for you and your eligible spouse and dependents.

This document summarizes the benefits provided by the Town of Northborough under the HRA for its eligible Employees and Retirees. It does not include every detail of the Plan. In all situations involving the interpretation or clarification of a policy, procedure or application, the decision of the Plan Administrator will be final and binding. Notwithstanding the foregoing, any claim for benefits that the Plan Administrator denies is subject to review pursuant to the Claims Procedures Section specified in this Summary.

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HEALTH REIMBURSEMENT ARRANGEMENT
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1. GENERAL PLAN INFORMATION

Plan Name: Town of Northborough Health Reimbursement Arrangement

Type of Plan: The Plan is a self-insured health reimbursement arrangement

Plan Year: A 12-month period beginning July 1st and ending on June 30th.

Plan Sponsor: Town of Northborough
63 Main Street
Northborough, MA 01532

FEIN 04-6001249

Plan Administrator: Town of Northborough

Agent of Service of Legal Process: Lisa M. Troast
Treasurer/Collector
Town of Northborough
63 Main Street
Northborough, MA 01532

Service of legal process may be made to the Plan Administrator or the legal agents at the business address listed above.

Effective Date of the Plan: June 1, 2013

Date of this SPD: April 25, 2023

2. IMPORTANT DEFINITIONS

As you read about your benefits, you may find terms, which have specific meaning. This section lists important terms and their meanings under the Plan. Any term not included in this section, but used in this Summary, shall have the same meaning as specified in the Plan.

Dependent means any dependent who is enrolled as a dependent of an Employee and/or a Retiree in Town of Northborough's group health care plan. Notwithstanding the foregoing, the Plan will provide benefits in accordance with the applicable requirements of any Qualified Medical Care Support Order (QMCSO), even if the child does not meet the definition of "Dependent."

Eligible Medical Care Expenses means the co-pay amounts for in-patient and out-patient hospitalizations and high-tech imaging that a Participant is required to pay during the Plan Year under the Town's plans provided by Fallon Community Health Plan for which no policy of insurance provides reimbursement.

Employee means any employee of the Town who is regularly scheduled to work at least twenty (20) hours a week and who is considered to be in a legal employer-employee relationship with the Town for federal withholding tax purposes.

ERISA means the Employee Retirement Income Security Act of 1974, as amended.

FMLA means the Family and Medical Leave Act of 1993, as amended.

HIPAA means the federal Health Insurance Portability and Accountability Act, which is a far-reaching legislation designed to improve the portability of health coverage and to make other changes to the health care delivery system.

Insurer means the insurance company that provides benefits under the Medical Plan.

Protected Health Information ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations.

Medical Plan means the group health care plan sponsored by the Town.

Retiree means any former employee of the Town of Northborough who retires or is retired from the Town, is eligible to collect pension benefits from Worcester Regional Retirement System or the Massachusetts Teachers Retirement System ("MTRS"), is not eligible for Medicare and who is enrolled in Town's plans provided by Harvard Pilgrim Health Care.

Spouse means an individual who is enrolled as a spouse (either of the opposite sex or the same sex) of an Employee or Retiree in Town of Northborough's group health care plan.

Town means the Town of Northborough.

3. ELIGIBILITY AND PARTICIPATION REQUIREMENTS

Who may participate in the Plan?

You will be automatically enrolled in this Plan, if you are an Employee of the Town, you are enrolled in the group health care coverage offered by the Town.

You will also be automatically enrolled in this Plan, if you are a Retiree of the Town, are enrolled in the group health care coverage offered by the Town, and you are not eligible for Medicare.

Does your participation in the Plan end if the Town grants you a leave of absence?

If you are an Employee of the Town who is eligible for a qualified leave under FMLA, then to the extent required by FMLA, as applicable, the Town will continue to maintain your benefits

under the Plan on the same terms and conditions as if you were still considered an active Employee.

If you are an Employee of the Town who is eligible for leave under USERRA, you may elect to continue coverage for up to 24 months after the absence begins, or the period of absence, whichever is shorter. You cannot be required to pay more than 102% of the full premium for the group health care coverage under your Town's group health care plan.

On your return from active duty and leave, your participation will be reinstated without any waiting period or exclusions for preexisting conditions, other than waiting periods or exclusions that would have applied even if there had been no absence for uniformed service.

If you are an Employee of the Town who is eligible for leave of absence that is not subject to FMLA or USERRA, you will be treated as an active employee during your leave.

4. BENEFITS

What benefits does the Plan provide?

Once you meet the eligibility requirements, you will receive reimbursement of Eligible Medical Care Expenses incurred by you, your Spouse and/or your Dependents during a Plan Year, if you have not been previously reimbursed for such expenses and will not seek reimbursement of the expenses elsewhere. Eligible Medical Care Expenses means $1,000.00 for the co-pay amount for each inpatient hospitalization, $500.00 for the co-pay amount for each out-patient hospitalization and $250 for the co-pay amount for each high-tech imaging procedure that an Employee and/or Retiree is required to pay during the Plan Year under the Town's plans provided by Harvard Pilgrim Health Care.

Eligible Medical Expenses must be reimbursed by this Plan to the extent that they can be before any such expenses may be submitted for reimbursement by the health flexible spending arrangement under the section 125 cafeteria plan maintained by the Town.

What must you do to have the Plan reimburse Eligible Medical Care Expenses?

When you incur an Eligible Medical Care Expense that is eligible for payment, you must submit a claim to the Plan Administrator on an Expense Reimbursement Form that will be supplied to you and include an Explanation of Benefits (EOB) Form from the Insurer (or a bill from a doctor's office) indicating the amounts that you are obligated to pay.

You will be reimbursed for your Eligible Medical Care Expenses within 30 days after the date you submitted the Expense Reimbursement Form (subject to a 15-day extension for matters beyond the Plan Administrator's control).

You will have until the end of the 90-day period following the end of the Plan Year to submit a claim for reimbursement for Eligible Medical Care Expenses incurred during the previous Plan Year. You will be notified in writing if any claim for benefits is denied.

To have your claims processed as soon as possible, it is not necessary for you to have actually paid the bill - only that you incur the expense, and that it is not being paid for or reimbursed from any other source.

Will you be taxed on reimbursements you receive under the Plan?

No. Generally, reimbursements for Eligible Medical Care Expenses are not taxable. However, the Town cannot guarantee that specific tax consequences will flow from your participation in the Plan. The tax benefits that you receive depend on the validity of the claims you submit.

What is a Certificate of Creditable Coverage?

When you or your Dependents lose medical coverage, the Town's insurance carrier will mail a certificate of creditable coverage to your home.

This certificate may be used, in accordance with HIPAA, to prove you were covered under a health plan for a certain length of time. The certificate will prove that you had coverage for a maximum of up to 18 months. You can use this certificate to offset and possibly eliminate pre-existing condition exclusions that may apply under group health plans in which you later participate.

5. COBRA COVERAGE

What is COBRA coverage?

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Town is required to provide you and your Qualified Beneficiaries with the opportunity to reimburse Eligible Medical Care Expenses under the Plan for a limited period of time after termination of your participation in the Plan, unless your participation was terminated due to gross misconduct. This coverage is paid by you or your Qualified Beneficiaries when certain defined events occur that otherwise would cause you and/or your Qualified Beneficiaries to lose coverage.

Please note that COBRA coverage will not be offered if you or your Qualified Beneficiaries were not eligible for benefits under the Plan prior to your qualifying event.

While you are eligible for COBRA, there may be other coverage options for you and your family. You may be able to buy coverage through the Health Insurance Marketplace. In the Marketplace, you could be eligible for a new kind of tax credit that lowers your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit through the Marketplace. Additionally, you may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a spouse's plan), even if the plan generally does not accept late enrollees, if you request enrollment within 30 days.

What benefits available through COBRA coverage?

Following a qualifying event (described below), the Town must offer you and your Qualified Beneficiaries the opportunity to pay the full cost of the same medical coverage you had when you were an active employee. The opportunity to elect the same coverage that you had at the time the qualifying event occurred extends to all Qualified Beneficiaries.

The COBRA coverage that the Town offers is not fixed. If the Town changes the terms for medical reimbursement for regular Employees, Spouses and Dependents, these changes also apply to you and your Qualified Beneficiaries under COBRA. Also, Qualified Beneficiaries will have the same opportunity as active employees to change benefit elections during annual enrollment or special enrollment periods for medical plan options previously elected.

Who is a Qualified Beneficiary?

This term refers to your Spouse and/or dependent child(ren) who are or were covered under one of the Town's medical plans, and who have experienced a qualifying event that leads to a loss of coverage. This also includes a child who is born or placed for adoption with you during the period of COBRA coverage. Whether an individual is a "Qualified Beneficiary" is important because each Qualified Dependent has a separate right to elect COBRA coverage. COBRA documents may use the term "qualified beneficiary" which refers to you and your Qualified Beneficiaries.

Please remember that if you did not enroll any of your Dependents in any of the Town's medical plans (for whatever reason) prior to a qualifying event, even though they were otherwise eligible, they will not be considered Qualified Beneficiaries for COBRA coverage.

What events trigger COBRA coverage?

COBRA coverage is offered to you and/or your Qualified Beneficiaries when a qualifying event occurs. A qualifying event is defined as a loss of medical coverage due to one of the following reasons:

- Your death;
- A change of your employment status - such as your termination of employment from the Town or reduction in working hours;
- Your divorce or legal separation;
- You or any of your qualified beneficiaries are on military leave under USERRA;
- You elect Medicare as primary coverage; or
- Your dependent child loses eligibility for coverage.

What is the maximum length of COBRA coverage?

The general rule is that following your COBRA enrollment, COBRA coverage extends for 18 months from the first day of the month following a qualifying event if the event is your termination or reduction in hours. However, a special 18-month extension (for a total COBRA period of 29 months) is available to Qualified Beneficiaries who become disabled (according to Title II or XVI of the Social Security Administration Act) at the time of a qualifying event or are disabled within the first 60 days of COBRA coverage. In addition, the 29-month coverage period also applies to your non-disabled Qualified Beneficiaries if he or she is disabled. For all other qualifying events, COBRA coverage will be offered for 36 months.

Special "multiple qualifying event" rules allow your Qualified Beneficiaries who receive COBRA coverage upon your termination of employment or reduction in hours to extend the length of their coverage if a second qualifying event - such as your divorce or death - occurs during the initial 18-month period. In no event will COBRA coverage continue for more than 36 months.

When can COBRA coverage be terminated early?

COBRA coverage is offered to you and/or your Qualified Beneficiaries (for 18, 29 or 36 months) can be terminated early under any of the following circumstances:

- You, or your Qualified Beneficiaries, fail to make a timely COBRA premium payment. An initial premium payment following the election of COBRA coverage is considered timely if received within 45 days of such election. Any subsequent premium is considered timely if it is paid within 30 days from the due date;

- You or your Qualified Beneficiary receives coverage under another group plan after the date of election. COBRA coverage will be terminated if a Qualified Beneficiary becomes covered under any other group health plan that contains no restrictions or limitations on coverage of "pre-existing conditions" after the date of his or her COBRA election;

- The Town terminates all health plans;

- You or your Qualified Beneficiaries become entitled after the date of election to Medicare;

- Determination is made that you or your Qualified Beneficiaries are no longer disabled. This is applicable to disabled Qualified Beneficiaries that were granted 11 months of COBRA coverage in addition to the original 18-month coverage period. COBRA coverage will terminate at the beginning of the next month after there has been a determination by the Social Security Administration that the individual is no longer disabled. You, or your Qualified Beneficiaries are required to notify the Plan Administrator within 30 days of such determination;

- You notify the Plan Administrator that you wish to cancel, your coverage; or

- For cause, on the same basis that the Plan terminates for cause the coverage of similarity situated non-COBRA participants.

What are your or your Dependents notification requirements?

You or your Dependents must notify the Town if your Spouse either divorces or legally separates from you or if your Dependent(s) loses their "eligibility status" under the plan. You are required to notify the Town of family status changes within 31 days of the event date. Your enrollment change will trigger a COBRA information and enrollment kit to be mailed.

If you do not make enrollment changes within 31 days or if your Qualified Beneficiaries wish to notify the Town of the qualifying event, then you, your Spouse or Dependents must notify the Plan Administrator. Such notification must be made within 60 days of the qualifying event or the date your Qualified Beneficiaries would lose coverage as a result of the qualifying event, whichever is later. Loss of coverage occurs either on the last day of the month in which the qualifying event occurs or coverage is lost.

Remember that the Town will not have to offer any Qualified Beneficiaries the opportunity to elect COBRA coverage if you or your Qualified Beneficiaries fail to provide the required notice of a qualifying event.

To qualify for the 11-month extension of COBRA coverage, disabled Qualified Beneficiaries must notify the Plan Administrator, if different, of their disability status within 60 days of their disability determination by the Social Security Administration. Such notice must be given no later than the end of the regular 18-month COBRA coverage period that applies whenever there is a change in employment status.

When will you or your Qualified Beneficiaries be given notice of your COBRA rights?

When the Town receives notice of a qualifying event, the Plan Administrator, is required to notify you and your Qualified Beneficiaries in writing of your COBRA rights. If you, your Spouse and dependent child(ren) live together at the same address, the Plan Administrator satisfies this requirement by mailing one notice addressed to you. The notice will be mailed to your current address on file. It is important to keep your address information current on file with the Town and the Plan Administrator. Following the Town's receipt of notice of the qualifying event, the Town has 30 days to notify the Plan Administrator from the qualifying event or the loss of coverage, whichever is later. The Plan Administrator has 14 days from the date of receiving notice of any qualifying event to mail the notification.

When must you or your Qualified Beneficiaries elect COBRA coverage?

Once you and your Qualified Beneficiaries receive notice of your COBRA rights from the Plan Administrator, you have 60 days from the date of the notification, or the date your coverage terminates (whichever is later), to elect COBRA coverage. You or your Qualified Beneficiaries elect COBRA coverage by completing and returning the election form, sent with the notice, to the appropriate administrator at the address listed on the form by the deadline indicated above.

Qualified Beneficiaries may waive their rights to COBRA coverage rather than make a COBRA election. However, Qualified Beneficiaries are permitted to revoke such waiver if they change

their minds and decide to elect COBRA coverage at any time during the 60-day election period. If Qualified Beneficiaries revoke a waiver, coverage does not have to be provided for any period before the revocation. Once the 60-day election period ends, the waiver cannot be revoked.

Do your Qualified Beneficiaries have independent election rights under COBRA?

Yes. Each Qualified Beneficiary may independently elect or waive COBRA coverage.

For example, although you may not elect COBRA coverage on your own behalf, your Qualified Beneficiaries may elect COBRA coverage independently of you. In addition, if there is a choice among types of coverage, each Qualified Beneficiary is entitled to make a separate election from among the different types of coverage offered under the various plan options. So, even if you elect certain coverage, your Spouse or other Dependents may elect different coverage.

Although the Town allows Qualified Beneficiaries to make separate COBRA elections, you or your Spouse (except in the case of your death or divorce or legal separation), are permitted to make the election on behalf of other Qualified Beneficiaries affected by the qualifying event. In such cases, you or your Spouse's decision is binding on the other Qualified Beneficiaries in the family and the other family members lose their right to make an independent election.

Qualified Beneficiaries have the right to make a separate COBRA election for each medical plan option they were covered under prior to a qualifying event. However, they do not have an independent right to make their own after-tax contributions to a cafeteria plan.

Must you keep the Plan informed of any address changes?

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator or the Plan Administrator.

What amount do you and your Qualified Beneficiaries pay for COBRA coverage?

The premium the Town charges you and your Qualified Beneficiaries for COBRA coverage is based on the applicable total (the Town) premium cost under the medical plan options for "similarly situated" employees. The Town charges the covered Employee and his Qualified Beneficiaries no more than 102% of the applicable plan option premium cost. The additional 2% above the premium cost covers the Town's cost of administering COBRA.

Disabled Qualified Beneficiaries that are granted the special 11-month extension are charged up to 150% (rather than 102%) of the applicable plan premium during the 11-month period of extended coverage.

6. PRIVACY RIGHTS

What disclosures of enrollment/disenrollment information are permitted?

The Plan may disclose to the Town information on whether you are participating in the Plan, or are enrolled in or have disenrolled in the Plan. For purposes of this article, "Protected Health Information" ("PHI") means individually identifiable health information that is maintained or transmitted by a covered entity, subject to specified exclusions as provided in federal regulations. For purposes of this article, Electronic Protected Health Information or Electronic PHI means PHI that is transmitted by or maintained in electronic media.

What uses and disclosures of summary health information are permitted?

The Plan may disclose Summary Health Information to the Town, provided the Town requests the Summary Health Information for the purpose of (a) obtaining premium bids from health plans for providing health insurance coverage under the Plan; or (b) modifying, amending, or terminating the Plan.

"Summary Health Information" means information that (a) summarizes the claims history, claims, expenses, or type of claims experienced by individuals for whom the Town had provided health benefits under the Plan; and (b) from which the identifying information has been deleted, except that the geographic information need only be aggregated to the level of a five-digit zip code.

What required uses and disclosures of PHI are permitted for Plan administrative purposes?

Unless otherwise permitted by law, and subject to the conditions of disclosure and obtaining written certification, the Plan (or an insurance company on behalf of the Plan) may disclose PHI and Electronic PHI to the Town, provided the Town uses or discloses such PHI and Electronic PHI only for Plan administration purposes. "Plan administration purposes" means administration functions performed by the Town on behalf of the Plan, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Town in connection with any other benefit or benefit plan of the Town, and they do not include any employment-related functions.

The Town is not permitted to use or disclose PHI in a manner that is inconsistent with federal regulations.

Under what conditions can PHI be disclosed for plan administration purposes?

The Town agrees that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the Plan (or an Insurer on behalf of the Plan), the Town shall:

- not use or further disclose the PHI other than as permitted or required by the Plan or as required by law;

- ensure that any agent, including a subcontractor, to whom it provides PHI received from the Plan agrees to the same restrictions and conditions that apply to the Town with respect to PHI.

- not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Town;

- report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for;

- make available PHI to comply with HIPAA's right to access in accordance with federal regulations;

- make available PHI for amendment and incorporate any amendments to PHI in accordance with federal regulations.

- make available the information required to provide an accounting of disclosures in accordance with federal regulations;

- make its internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Secretary of Health and Human Services for purposes of determining compliance by the Plan with HIPAA's privacy requirements;

- if feasible, return or destroy all PHI received from the Plan that the Town still maintains, in any form, and retain no copies of such information when no longer needed for the purpose for which disclosure was made, except that, if such return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the information infeasible; and.

- ensure that the adequate separation between the Plan and the Town (i.e. the "firewall"), required in federal regulations, is established.

- The Town further agrees that it creates, receives, maintains or transmits any Electronic PHI (other than enrollment/disenrollment information and Summary health Information and information disclosed pursuant to a signed authorization that complies with the federal requirements which are not subject to these restrictions) on behalf of the Plan, it will:

- implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of the Electronic PHI that it creates, receives maintains or transmits on behalf of the Plan;

- ensure that the adequate separation between the Plan and the Town (i.e., the firewall), is supported by reasonable and appropriate security measures;

- ensure that any agent, including a subcontractor, to whom it provides Electronic PHI agrees to implement reasonable and appropriate security measures to protect the information; and

- report to the Plan any security incident of which it becomes aware, as follows: the Town will report to the Plan, with such frequency and at such times as agreed, the aggregate number of unsuccessful, unauthorized attempts to access, use, disclose, modify, or destroy Electronic PHI or to interfere with systems operations in an information system containing Electronic PHI; in addition the Town will report to the Plan as soon as feasible any successful unauthorized access, use disclosure, modification or destruction of Electronic PHI or interference with systems operations in an information system containing Electronic PHI

Who is permitted to disclose information?

The Town may specify those employees who will have access to PHI. No other persons shall have access to PHI. These specified employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Town performs for the Plan. In the event that any of these specified employees do not comply with the provisions of this Section, that employee shall be subject to disciplinary action by the Town for non-compliance pursuant to the Town's employee discipline and termination procedures.

The Town shall ensure that the provisions of this section are supported by reasonable and appropriate security measures to the extent that the persons designated above create, receive, maintain, or transmit Electronic PHI on behalf of the Plan.

When Can the Plan disclose PHI to the Town?

The Plan may disclose PHI to the Town only upon the receipt of a certification by the Town that the Plan has been amended to incorporate the provisions of federal regulations, and that the Town agrees to the conditions of disclosure set forth in this summary.

7. CLAIMS PROCEDURES

How do you file for benefits under the Plan?

For purposes of determining the amount of, and entitlement to reimbursement for Eligible Medical Care Expenses under the Plan, the Plan Administrator has the full power to make factual determinations and to interpret and apply the terms of the Plan as they relate to the benefits provided through a self-funded arrangement.

To obtain benefits, you must complete, execute and submit an Expense Reimbursement Form to the Plan Administrator.

The Plan Administrator will decide your claim in accordance with reasonable claims procedures, as required by ERISA. The Plan Administrator has the right to require such other evidence, as it deems necessary in order to decide your claim. If the Plan Administrator denies your claim, in whole or in part, you will receive a written notification setting forth the reason(s) for the denial.

What happens if your claim for benefits was denied?

If your claim is denied in whole or in part, you will be notified in writing by the Plan Administrator within 30 days of the date the Plan Administrator received your claim. (This time-period may be extended for an additional 15 days for matters beyond the control of the Plan Administrator, including in cases where a claim is incomplete.)

The Plan Administrator will provide written notice of any extension, including the reasons for the extension and the date by which a decision by the Plan Administrator is expected to be made. Where a claim is incomplete, the extension notice will also specifically describe the required information, will allow you 45 days from receipt of the notice in which to provide the specified information, and will have the effect of suspending the time for a decision on your claim until the specified information is provided.

Notification of a denied claim will set out:

- a specific reason or reasons for the denial;
- the specific Plan provision on which the denial is based;
- a description of any additional material or information necessary for you to validate the claim and an explanation of why such material or information is necessary;
- appropriate information on the steps to be taken if you wish to appeal the Plan Administrator's decision, including your right to submit written comments and have them considered, your right to review (upon request and at no charge) relevant documents and other information, and your right to file suit under ERISA with respect to any adverse determination after appeal of your claim.

Appeals under the Plan. If your claim is denied in whole or part, you (or your authorized representative) may request review upon written application to the Named Fiduciary.

Your appeal must be made in writing within 180 days of your receipt of the notice that the claim was denied. If you do not appeal on time, you will lose the right to appeal the denial and the right to file suit in court.

Your written appeal should state the reasons that you feel your claim should not have been denied. It should include any additional facts and/or documents that you feel support your claim.

You will have the opportunity to ask additional questions and make written comments, and you may review (upon request and at no charge) documents and other information relevant to your appeal.

Decision on Review. Your appeal will be reviewed and decided by the Named Fiduciary or other entity designated in the Plan in a reasonable time not later than 60 days after the Named Fiduciary receives your request for review. The Named Fiduciary may, in its discretion, hold a hearing on the denied claim. Any medical expert consulted in connection with your appeal will be different from and not subordinate to any expert consulted in connection with the initial claim

denial. The identity of a medical expert consulted in connection with your appeal will be provided. If the decision on review affirms the initial denial of your claim, you will be furnished with a notice of adverse benefit determination on review setting forth:

- The specific reason(s) for the decision on review;

- The specific Plan provision(s) on which the decision is based;
- A statement of your right to review (upon request and at no charge) relevant documents and other information;

- If an "internal rule, guideline, protocol, or other similar criterion" is relied on in making the decision on review, a description of the specific rule, guideline, protocol, or other similar criterion or a statement that such a rule, guideline, protocol, or other similar criterion was relied on and that a copy of such rule, guideline, protocol, or other criterion will be provided free of charge to you upon request; and

- A statement of your right to bring suit under ERISA.

8. MISCELLANEOUS PROVISIONS

When does your participation under the Plan end?

Your participation in this Plan will cease if you are an Employee of the Town and you fail to meet either of the following requirements: (1) you are regularly scheduled to work at least 20 hours a week, and (2) you are enrolled in the group health care coverage offered by the Town.

Your participation in this Plan will cease if you are a Retiree of the Town and or you fail to meet either of the following requirements: (1) you are enrolled in the Town's group health care plan Town, and/or (2) you are NOT eligible for Medicare.

If you fail to meet the eligibility provisions for participation in this Plan, you or your Dependents otherwise become ineligible for benefits (i.e. because of divorce), your participation (as well as your Dependents) under Plan will end on last day of the month that your termination or loss of eligibility occurs.

If the Town decides to terminate the Plan, coverage will end on the termination date.

Your participation in the Plan will also terminate if you file a false claim under the Plan.

Who makes benefit determinations?

The Town reserves the exclusive discretionary right to interpret the Plan and make all factual determinations, including matters of eligibility for benefits.

What rights does the Town have under the Plan?

The Town intends to maintain this Plan indefinitely. However, the Town reserves the right to terminate, modify, ammend or change the Plan by written action of the Board of Selectmen of the Town. Your participation in the Plan does not guarantee the availability of benefits in the future. The Town will notify Participants of any changes through the Town's employee publications, including annual enrollment materials and updates to this and other relevant summaries.

Your participation in the Plan does not guarantee the availability of benefits in the future. The language used in this document is not intended to create, nor is it to be construed to constitute, a contract between the Town and any of its employees for either employment or the provision of any benefit. Employment for employees of the Town remains at-will.