BETH ISRAEL LAHEY HEALTH, INC.
EMPLOYEE BENEFITS PLAN

Plan Document & Summary Plan Description

Effective January 1, 2025

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Plan Identifying Information

Plan Name:	Beth Israel Lahey Health, Inc. Employee Benefits Plan
Plan Sponsor:	Beth Israel Lahey Health, Inc. 20 University Road, Suite 700 Cambridge, MA 02138 617-278-8800
Participating Employers:	A list of all participating Employers may be obtained upon request from the Plan Administrator.
Plan Number:	501
Plan Type:	Health and Welfare Benefits Wrap Plan
Plan Sponsor EIN:	83-2671600
Plan Effective Date:	January 1, 2020
Plan Year:	January 1 to December 31
Plan Administrator:	Beth Israel Lahey Health, Inc. Attn: Human Resources 20 University Road, Suite 700 Cambridge, MA 02138 617-278-8800
Agent for Service of Legal Process:	Beth Israel Lahey Health, Inc. Attn: General Counsel 20 University Road, Suite 700 Cambridge, MA 02138 617-278-8800

Directory of Contract Administrators

Contract administrators are responsible for the day-to-day administration of certain health and welfare benefit programs under this Plan, including the payment of benefits. The Component Benefit Programs for which each contract administrator provides services are fully identified on the Employer Schedules.

ARAG	800-247-4184 https://www.ARAGLegal.com/myinfo Access Code: 10183bil
BenefitHub	866-664-4621 Bilhperks.benefithub.com Referral Code: BE1UCI
Blue Cross Blue Shield of Massachusetts [BIDMC & MAH Post-65 retirees]	800-821-1878 (TTY) 711 bluecrossma.com/myblue
Blue Cross Blue Shield of Massachusetts [Winchester Post-65 retirees]	888-543-4917 (TTY/TDD 711) http://groups.rxmedicareplans.com
Care@Work	855-781-1303 BILH.care.com
Delta Dental of Massachusetts	800-368-4708 deltadentalma.com
ESI [Northeast Post-65 retirees]	800-236-4782 (TTY users should call 711)
ESI [Winchester post-65 retirees]	888-543-4917 http://groups.rxmedicareplans.com
EyeMed	866-723-0514 www.eyemedvisioncare.com
FMLASource	844-587-1700 fmlasource.com
Harvard Pilgrim Healthcare	866-623-0194 harvardpilgrim.org/bilh
KGA	855-760-BILH (2454) https://my.kgslifeservices.com/?org_code=bilh

Sentinel (Flexible Spending Accounts)	888-762-6088 www.sentinelgroup.com
BILH HR Service Center	617-667-5000 Create a case in Workday
InScript	855-542-1819 www.inscriptrx.org For mail-order pharmacy contact: bilh-pharmacydirect@bilh.org For specialty pharmacy contact: Specialty PharmacyRxClaims@bidmc.harvard.edu
Transamerica [Northeast Post-65 retirees]	Benistar Customer Service at 800-236-4782
Tufts Health Plan [MAH Post-65 retirees]	800-936-1902 (TTY: 711) www.thpmp.org
Unum	800-321-3889
Voya	800-955-7736 www.voya.com

I. Introduction

Beth Israel Lahey Health, Inc. ("BILH") hereby amends and restates this Employee Benefits Plan effective January 1, 2025. The Plan is maintained for the exclusive benefit of Eligible Employees and Eligible Retirees of BILH and its Affiliates, and their eligible family members. The Plan provides specified health and welfare benefits through Component Benefit Programs offered by BILH and its Affiliates, which are described in separate Component Benefit Program documents.

This Plan document is intended to comply with all relevant applicable provisions of the Internal Revenue Code and ERISA and is to be interpreted in a manner consistent with the requirements of both laws. The Plan consists of this document and the Component Benefit Program documents. The provisions of the Component Benefit Programs are incorporated by reference into this Plan document and govern the benefits provided under the programs.

This document and the Component Benefit Program documents together constitute the written plan document required by ERISA and constitute a single plan under ERISA for purposes of satisfying the reporting requirements of ERISA Title I. This document is intended to serve as both a plan document and as a summary plan description with respect to the Plan. This document and the Component Benefit Program documents govern administration of the Plan in all respects.

II. Definitions

Wherever used in this Plan, the following capitalized terms have the following meanings, and the singular includes the plural, unless a different meaning is clearly required by the context:

ACA	The Patient Protection and Affordable Care Act, commonly called the Affordable Care Act.
Administrator (or Plan Administrator)	BILH or such other person or committee as may be appointed from time to time by BILH to supervise the administration of the Plan.
Affiliate	BILH and any member of the group of organizations that is considered a single employer with BILH for purposes of federal benefits law. This includes employers that are aggregated with BILH under Code § 414(b), (c), (m), and (o) and regulations that include special rules for tax-exempt entities.
BILH	Beth Israel Lahey Health, Inc. and any successor to all or a major portion of its assets or business that adopts this Plan. BILH is the Plan sponsor.
Claims Administrator	The entity to which the Plan Administrator has delegated the authority to determine entitlement to and the amount of benefits under its respective Component Benefit Program. When acting as claims administrator, the Insurance Company or third-party administrator has the sole discretionary authority to interpret the Plan and make factual determinations.

Code	The Internal Revenue Code of 1986, as amended from time to time. Reference to any section or subsection of the Code includes reference to any regulations thereunder and any comparable or succeeding provisions of any legislation which amends, supplements, or replaces such section or subsection.
Component Benefit Program	Any contractual arrangement maintained by an Employer to provide group health and welfare benefits and listed in the applicable Employer Schedule. In the case of any Component Benefit Program that includes more than one coverage option, reference to the program is a reference to all coverage options under the Program. Each Component Benefit Program is described in and subject to a separate written plan document, insurance certificate or contract, benefit summary, or other governing document (a "Component Benefit Program document"). When the Plan refers to a Component Benefit Program document, that reference includes any attachments to the document and to documents incorporated by reference into the Component Benefit Program document (such as, in the case of an insurance contract, the application and the certificate of insurance booklet).
Contributory Coverage	Coverage under a Component Benefit Program for which Eligible Employees or Eligible Retirees are required to contribute all or a portion of the cost of providing coverage to Participants and, if applicable, their Eligible Dependents.
Eligible Dependent	A family member of an Eligible Employee or Eligible Retiree who may be covered under a Component Benefit Program, as specified in the applicable Component Benefit Program. If a Component Benefit Program does not include a definition of Eligible Dependent, Eligible Dependent shall mean a dependent as defined in Code § 152 who meets all other requirements for eligibility for the Component Benefit Program. If the Component Benefit Program is a group health plan, Code § 152 in the previous sentence shall be replaced with Code § 105(b).
Eligible Employee	An Employee who is eligible for benefits under one or more of the Component Benefit Programs, as specified in the applicable Employer Schedule. BILH may at any time and from time to time add or remove any one or more group(s) or class(es) of Employees from eligibility for participation in this Plan. The determination of an Employee's eligibility to participate in the Plan shall be made by the Administrator and shall be binding and conclusive upon all persons.

Eligible Retiree	A former Employee who is eligible for benefits under one or more of the Component Benefit Programs, as specified in the applicable Employer Schedule.
Employee	An individual who provides services to an Employer as a common law employee. Unless otherwise specified on the applicable Employer Schedule, "Employee" does not include independent contractors, leased employees within the meaning of Code § 414(o)(2), individuals designated by the applicable Employer as temporary or seasonal employees, per diem employees, or employees subject to a collective bargaining agreement between the Employer and employee representatives unless the collective bargaining agreement specifically provides for participation in this Plan or a Component Benefit Program. "Employee" also includes any otherwise excluded individual to the extent necessary to avoid the imposition of an assessment under Code Section 4980H. The determination of whether an individual is an Employee, an independent contractor, a per diem employee, or any other classification of worker or service provider and the determination of whether an individual is classified as a member of any particular classification of employees shall be made in accordance with the classifications used by the Employer (as applied by the Plan Administrator) and shall not be dependent on, or change due to, the treatment of the individual for any purposes under the Code, common law or any other law, or any determination made by any court or government agency.
Employer	BILH and each Affiliate that makes available one or more Component Benefit Programs to its Employees and/or former Employees with the approval of BILH.
Employer Schedule	A Schedule included in this Plan that provides benefit eligibility and other rules applicable to the Component Benefit Programs and Employees of a particular Employer or Employers.
ERISA	The Employee Retirement Income Security Act of 1974, as amended from time to time. Reference to any section or subsection of ERISA includes reference to any regulations thereunder and any comparable or succeeding provisions of any legislation which amends, supplements or replaces such section or subsection.
Flexible Benefit Plan	Any Component Benefit Program that is a cafeteria plan within the meaning of Code § 125, offering eligible employees a choice between cash compensation and qualified benefits (also known as premium conversion).

Insurance Company	A duly-licensed insurance company, health maintenance organization, or other provider that has contracted with the applicable Employer to provide fully insured or capitated benefits under the Plan.
Non-Contributory Coverage	Coverage under a Component Benefit Program for which the applicable Employer pays the full cost of providing coverage to Participants and, if applicable, to their Eligible Dependents.
Participant	An Eligible Employee or Eligible Retiree who is covered by one or more Component Benefit Programs.
Plan	The Beth Israel Lahey Health, Inc. Employee Benefit Plan as set forth herein (including any and all amendments and supplements hereto) and the Component Benefit Programs, which are incorporated by reference into the Plan.
Plan Year	The calendar year

III. Eligibility and Participation Requirements

A. *Eligibility and Participation*. An Eligible Employee is any Employee who is eligible to participate in and receive benefits under one or more of the Component Benefit Programs, as specified in the applicable Employer Schedule and Component Benefit Program documents. An Eligible Employee may begin participating in the Plan in accordance with the terms and conditions established in the Employer Schedule and Component Benefit Program. An Eligible Employee's family members also may be eligible to participate in and receive benefits from one or more of the Component Benefit Programs, as and to the extent allowed in the applicable Component Benefit Program documents. If an Eligible Employee is employed by multiple Affiliates in benefits eligible positions, the Eligible Employee's benefits will be determined according to the Employer Schedule for the Affiliate that is designated as the Eligible Employee's primary employer. Whether an Employee has satisfied the service requirement for a particular Component Benefit Program will be determined by taking into account the sum of all regularly scheduled hours for that Employee across BILH and each Affiliate.

An Eligible Retiree is any former Employee who is eligible to participate in and receive benefits under one or more of the Component Benefit Programs, as specified in the applicable Employer Schedule and Component Benefit Program documents. An Eligible Retiree may begin participating in the Plan in accordance with the terms and conditions established in the Employer Schedule and Component Benefit Program. An Eligible Retiree's family members also may be eligible to participate in and receive benefits from one or more of the Component Benefit Programs, as and to the extent allowed in the applicable Component Benefit Program documents.

Certain Component Benefit Programs require an annual election and/or other requirements that must be met each Plan year to enroll in coverage. Except as otherwise provided in the separate Component Benefit Program documents, information about enrollment procedures, including when coverage begins and ends for the various Component Benefit Programs, is found in the

Flexible Benefit Plan. Certain Component Benefit Programs allow Eligible Employees to pay for their share of the cost of coverage on a pre-tax basis. The details of these administrative requirements are described in the Flexible Benefit Plan and Component Benefit Program documents.

B. *Termination of Participation*. Benefits for a Participant under this Plan will cease when he or she ceases to be eligible for benefits under any Component Benefit Program. Benefits will also cease upon termination of the Plan or the applicable Component Benefit Program. Benefits for a Participant's covered family members will cease when his or her coverage ceases or, if earlier, on the date on which an individual ceases to be eligible for benefits under particular Component Benefit Programs or when the Employee or former Employee fails to provide proof of continued eligibility as may be required by the Plan Administrator.

C. *Transfers Between Employers.* If an Eligible Employee under this Plan transfers directly from one Employer to another Employer that offers different Component Benefit Programs, the Employee's benefits will continue under the Component Benefit Programs of the new Employer. The Plan Administrator will provide detailed information if applicable.

D. *Continuation Coverage under COBRA.* As and to the extent required by law (including, without limitation, Section 4980B of the Code and regulations thereunder pertaining to COBRA continuation coverage), if coverage for a Participant or his or her eligible family members ceases under a Component Benefit Program that provides medical, dental, vision, or other health care benefits because of certain "qualifying events," such as termination of employment, reduction in hours, death, divorce, or a child ceasing to meet the definition of dependent, then the Participant and his or her eligible family members may have the right to purchase continuation coverage for a temporary period of time. COBRA rights are explained in detail in the Component Benefit Program documents.

E. *Continuation Coverage under USERRA.* Continuation and reinstatement rights may also be available if you are absent from employment due to service in the uniformed services pursuant to the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). More information about coverage available under USERRA is available from the Plan Administrator.

IV. Plan Benefits

A. *Benefits*. The Plan provides Participants and their eligible family members with benefits under the Component Benefit Programs listed on the Employer Schedules. The Component Benefit Programs under the Plan may change from time to time, and all benefits may not be available to all Participants in this Plan.

B. *Funding and Contributions.* The cost of the benefits provided through the Component Benefit Programs will be funded in part by Employer contributions and in part by Participant contributions. Participant contributions for some Component Benefit Programs may be made on a pre-tax basis under the applicable Flexible Benefit Plan. The Employers will determine and periodically communicate the Participants' share of the cost of the benefits provided through each Component Benefit Program, and each Employer may change its determination at any time.

The Employers will make contributions in an amount that, in their sole discretion, is at least sufficient to fund the benefits or a portion of the benefits that are not otherwise funded by Participant contributions. Each Employer will pay its contributions and Participant contributions to an insurance carrier or, with respect to benefits that are self-funded, will use these contributions to pay benefits directly to or on behalf of Participants, or the eligible family members of Participants, from the Employer's general assets. Participant contributions toward the cost of a particular benefit will be used in their entirety prior to using Employer contributions to pay for the cost of such benefit. Notwithstanding the foregoing, Participant contributions will not be used to pay for pharmacy benefits available under the Plan. Any refund, rebate, dividend, experience adjustment, or other similar payment under any group insurance contract entered into between an Employer and an insurance carrier to provide Plan benefits shall be allocated to reimburse the Employer for premiums it has paid or between the Employer and the Participants (and among the Participants), as determined by the Plan Administrator consistent with the fiduciary standards of ERISA.

Nothing in the Plan is intended to require the establishment of a trust. The Employers pay their portion of the cost of benefits under the Plan from their general assets.

C. *Qualified Medical Child Support Orders.* With respect to Component Benefit Programs that are group health plans, the Plan will provide benefits as required by any qualified medical child support order ("QMCSO," defined in ERISA Section 609(a)). The Plan has procedures for determining whether an order qualifies as a QMCSO. Participants and beneficiaries can obtain, without charge, a copy of the QMCSO procedures from the Plan Administrator.

V. Plan Administration

A. *Plan Administration.* The Plan Administrator has full and sole discretionary power to administer and operate the Plan in all of its details, subject to applicable requirements of law. For this purpose, in addition to all other powers provided by this Plan, the Plan Administrator's discretionary powers include, but are not limited to: determining all questions arising in connection with the Plan and the eligibility of any person to participate in the Plan; interpreting the provisions of the Plan and to construe all of its terms; computing and authorizing the payment of benefits under the Plan; adopting, amending, and rescinding rules and procedures for the administration of the Plan; and generally conducting and administering the Plan and to make all determinations in connection with the Plan as may be necessary or advisable. All such actions of the Plan Administrator will be conclusive and binding on all persons.

The Plan Administrator may delegate any of these administrative duties among one or more persons or entities, including any employee(s) of the Employers, any Insurance Company, and any contract administrator. The Claims Administrators identified in the applicable Employer Schedule are responsible for (a) determining the amount of any benefits payable for the applicable Component Benefit Program under the Plan; and (b) providing the claims procedures to be followed for that Component Benefit Program under the Plan. Moreover, the Claims Administrators maintain the full power and sole discretion to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable Component Benefit Plan and have the authority to require eligible individuals to furnish it with information it determines necessary for the proper administration of the Plan.

To the extent permitted by law, the Plan Administrator shall not incur any liability for any acts or for failure to act except for its own willful misconduct or willful breach of the Plan.

B. *Indemnification.* Each Employer agrees to indemnify and to defend to the fullest extent permitted by law any of its employees performing administrative duties with respect to the Plan and the Component Benefit Programs against all liabilities, damages, costs, and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the Plan Administrator) occasioned by any act or omission in connection with the Plan and the Component Benefit Programs, unless arising out of the employee's gross negligence, willful neglect, or willful misconduct. If a Participant or eligible covered family member receive one or more payments or reimbursements through the Plan on a tax-free basis that do not qualify for that treatment under the Code, the Participant must indemnify and reimburse the Employer for any liability that it may incur for failure to withhold federal income taxes, Social Security taxes, or other taxes from any payments or reimbursements.

VI. Circumstances That May Affect Benefits

A. *Denial or Loss of Benefits.* A Participant's benefits (and the benefits of his or her covered eligible family members) will cease when his or her participation in the Plan terminates as described in Article III. Benefits will also cease on termination of the Plan. Benefits under a particular Component Benefit Program will cease for a Participant or a family member of a Participant when the individual ceases to be eligible for the particular Component Benefit Program or on termination of such program, whichever occurs first.

B. *Other Circumstances and Recovery of Benefits.* The Component Benefit Program documents set forth other circumstances that may result in the termination, reduction, recovery (through subrogation or reimbursement), or denial of benefits (through coordination of benefits, failure to meet administrative requirements, or otherwise).

C. *Right to Recover Benefit Overpayments and Other Erroneous Payments.* If, for any reason, any benefit under the Plan is erroneously paid or exceeds the amount appropriately payable under the Plan to a Participant or a beneficiary, the Participant or the beneficiary shall be responsible for refunding the overpayment to the Plan. In addition, if the Plan makes any payment that, under the terms of the Plan, should not have been made, the applicable Insurance Company or contract administrator, the Plan Administrator, or the Employer may recover that incorrect payment, regardless of the cause or source of the error, from the person to whom it was made or from any other appropriate party. The refund or repayment may be made in one or a combination of the following methods: in the form of a single lump-sum payment; as a reduction of the amount of future benefits otherwise payable under the Plan; as automatic deductions from pay; or any other method as may be required or permitted in the sole discretion of the Plan Administrator, or applicable Insurance Company or contract administrator. The Plan may also seek recovery of the erroneous payment or benefit overpayment from any other appropriate party.

D. *Fraudulent Claims.* If an individual makes a material misrepresentation, falsifies any document in support of a claim for benefits or coverage under the Plan, or fails to correct information which such individual knows or should have known to be incorrect, or fails to bring such misinformation to the attention of the Plan Administrator or the applicable Insurance Company or contract administrator, the Plan Administrator may, without the consent of any person and to the fullest extent permitted by applicable law, terminate the individual's Plan coverage,

including retroactively. In addition, the applicable Insurance Company or contract administrator may refuse to honor any claim for benefits under the Plan related to the individual submitting the falsified information. Such individual shall be responsible to provide restitution, including monetary repayment to the Plan, with respect to any overpayment or ineligible payment of benefits.

VII. HIPAA Privacy Rights

A. *Use and Disclosure of Protected Health Information*. A federal law, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended, requires that health plans protect the confidentiality of your private health information. A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices or, if appropriate, in the privacy notice provided by the Insurance Company. Contact the Plan Administrator to obtain a copy of the Notice of Privacy Practices or if you have questions or complaints about the privacy of your health information.

Both the Employer and the Plan will use protected health information ("PHI") only to the extent of, and in accordance with, the uses and disclosures permitted under HIPAA. The Plan may use or disclose to the Employer information about whether an individual is participating in the Plan or has enrolled in or disenrolled from a health insurance issuer or HMO offered by the Plan. The Plan may also disclose summary health information to the Employer, as Plan Sponsor, so that the Employer may obtain premium bids or modify, amend, or terminate the Plan. Summary health information does not directly identify you, but summarizes your claims history, claims expenses, or types of claims experienced. In addition, and subject to the conditions of disclosure and obtaining the certification described in paragraph B below, the Plan may disclose PHI to the Employer for purposes of administering the Plan, such as for purposes related to payment and health care operations and administration, and as otherwise permitted or required by law.

Payment includes activities undertaken by the Plan to obtain premiums or fulfill its responsibility for coverage and provision of benefits that relate to an individual to whom the care is provided. These activities include, but are not limited to, the following:

- determination of eligibility and coverage;
- determination of cost sharing amounts;
- coordination of benefits;
- adjudication of benefit claims, including appeals and other payment disputes;
- subrogation of benefit claims;
- establishing employee contributions;
- billing and collection activities; and
- claims management and reporting.

Health care operations include, but are not limited to, the following activities:

- contacting health care providers and patients with information about treatment alternatives and related functions;
- underwriting or other such activities relating to the creation, renewal, or replacement of plan benefits;
- legal services and auditing functions;

- business management and general administrative activities of the Plan to include customer service and data analyses; and
- resolution of internal grievances.

B. *Use of PHI by Employer and Affiliates*. Subject to the conditions of disclosure described below, the Plan and any Component Benefit Programs thereunder may disclose PHI to the Employer and its Affiliates, provided the Employer and its Affiliates use or disclose the PHI only for plan administration functions. Plan administration functions do not include functions performed by the Employer in connection with any other benefit or benefit plan of the Employer, and they do not include any employment related functions. The Plan Administrator has received a certification from the Employer that the Plan has been amended to incorporate the following provisions and, with respect to any PHI disclosed to the Employer by the Plan or Component Benefit Programs (other than enrollment/disenrollment information and summary health information, which are not subject to these restrictions), the Employer will:

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

- ensure that any agents, including subcontractors, to whom the Employer provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Employer with respect to such PHI;

- not use or disclose PHI for employment-related actions and decisions unless authorized by an individual;

- not use or disclose PHI in connection with any other benefit or employee benefit plan of the Employer unless authorized by the individual who is the subject of the PHI;

- report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures permitted by HIPAA of which it becomes aware;

- make available a covered individual's PHI to that individual in accordance with HIPAA's privacy compliance rules ("Privacy Rules");

- make available PHI for amendment and incorporate any amendments to PHI in accordance with the Privacy Rules;

- track certain PHI disclosures it makes so that it can make available the information required for the Plan to provide an accounting of disclosures in accordance with the Privacy Rules;

- 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 the Privacy Rules;

- if feasible, return or destroy all PHI received from the Plan that the Employer maintains in any form and retain no copies of that PHI when it is 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 adequate separation of the Plan and Employer is established (as described below) and that such adequate separation is supported by reasonable and appropriate security measures.

    - The Employer and its Affiliates shall permit only the employees identified in Exhibit A to this Plan document ("Permitted Employees") to access PHI received from the Plan or its Component Benefit Programs.

    - Permitted Employees may only have access to and use and disclose PHI for plan administrative functions that the Employer performs for the Plan. In the event that any of the Permitted Employees do not comply with this Plan document, that individual shall be subject to corrective action up to and including termination of employment by the Employer (or Affiliate) for cause, pursuant to the Employer's (or Affiliate's) applicable employee corrective action policies or termination of the individual's engagement pursuant to any governing agreement, whichever is applicable.

C. *Security of Electronic PHI*. The Employer shall implement security measures to reasonably and appropriately safeguard electronic PHI of the Plan and its Component Benefit Programs in accordance with the HIPAA Security Rule. Specifically, the Employer shall:

- implement administrative, physical, and technical safeguards that will reasonably and appropriately protect the confidentiality, integrity, and availability of the electronic protected health information that it creates, receives, maintains, or transmits on behalf of the Plan and its Component Benefit Programs;

- ensure the adequate separation between the Plan and the Employer described above is supported by reasonable and accurate security measures;

- implement documents that ensure any agent, including a subcontractor, to whom it provides information 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.

VIII. Amendment or Termination of Plan

A. *Amendment of Plan*. BILH reserves the right at any time or times in its sole discretion to amend the Plan or any Component Benefit Program, by actions taken by BILH or any of its delegates. Unless otherwise provided, any such amendment will be effective for all Participants, whether or not employed by an applicable Employer. From time to time the Plan Sponsor shall update and revise the Employer Schedules and Exhibit A as necessary or desirable. Any such update or revision of the Employer Schedules and/or Exhibit A shall be considered a duly authorized amendment of this Plan. Termination of a particular Component Benefit Program is not a termination of the Plan; rather, it is an amendment to the Plan.

B. *Termination of Plan.* BILH may discontinue or terminate the Plan or any Component Benefit Program at any time, in its sole discretion. In the event the Plan or a Component Benefit Program is terminated, all contributions made by the applicable Employer will cease effective as of the date of termination and benefits will be paid or reimbursed with respect to claims incurred prior to or on the date of termination, provided that such claims are submitted within the time period prescribed under the applicable Component Benefit Program. In no event will benefits be paid or reimbursed with respect to claims incurred after the date of termination.

IX. Claims Procedures

A. *Claims for Fully Insured or Capitated Benefits.* For purposes of determination of the amount of, and entitlement to, benefits under a Component Benefit Program provided by an Insurance Company, the Insurance Company is the named fiduciary under the Plan, with the full power to interpret and apply the terms of the Plan as they relate to the benefits provided under the applicable insurance or other contract.

To obtain benefits under any such Component Benefit Program, the Participant or eligible covered family member must follow the claims procedures under the applicable Component Benefit Program document. The Insurance Company will decide the claim in accordance with its reasonable claims procedures, which will comply with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA. The Insurance Company may secure independent medical advice and require such other evidence as it deems necessary to decide a claim. The Insurance Company under any Component Benefit Program providing fully insured or capitated benefits, not the Employer, is responsible for paying claims under the program.

If the applicable Component Benefit Program document does not contain claims procedures that comply with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA, then the procedures outlined below in Section IX. C. "*General Claims Procedures"* will apply.

B. *Claims for Self-Funded Benefits.* For purposes of determining the amount of, and entitlement to, benefits under the Component Benefit Programs provided through the Employers' general assets, the Insurance Company or third-party administrator is the claims fiduciary under the Plan, with 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.

The claims fiduciary will decide a Participant's or eligible covered family member's claim in accordance with reasonable claims procedures, which, to the extent ERISA applies, will comply with ERISA and the regulations thereunder. The claims procedures applicable to each Component Benefit Program are described in the applicable Component Benefit Program document. The claims fiduciary may secure independent medical advice and require such other evidence as it deems necessary to decide a claim.

If the applicable Component Benefit Program document does not contain claims procedures that comply with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA, then the procedures outlined below in Section IX. C. "*General Claims Procedures"* will apply.

C. *General Claims Procedures*. This Section provides general information about the claims and appeals procedure applicable to the Plan under ERISA. If there are any discrepancies between the claims and appeals procedures in this Section and the applicable Component Benefit Program document, then the applicable Component Benefit Program document will govern so long as the claims and appeals procedures in the applicable Component Benefit Program document comply with comply with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA.

Claims Procedure Regarding Claims for Eligibility Under This Plan

If a claim under the Plan is denied in whole or in part, the claims fiduciary will notify you or your beneficiary in writing of the denial within 90 days of receipt of the claim. (This period may be extended to 180 days under certain circumstances.) The notification will be in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a description of any additional information needed to process the claim, and an explanation of the claims review procedure. Within 60 days after receipt of a notice of denial, you or your beneficiary may submit a written request for reconsideration of the application to the Plan Administrator.

You may review all pertinent documents related to an adverse determination and may request a review by the Plan Administrator of the decision denying the claim. Any request for a review must be filed in writing with the Plan Administrator within 60 days after you receive written notice of the claim decision. Your written request for review must contain all additional information that you want the Plan Administrator to consider, including written comments, documents, records, and other information relating to the claim. Any request for reconsideration should be accompanied by documents or records in support of your appeal. You or your beneficiary may review pertinent documents and submit issues and comments in writing.

The Plan Administrator will review the claim and provide, within 60 days, a written response to the appeal. (This period may be extended to 120 days under certain circumstances.) Any denial of your appeal will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire.

Claims Procedure for Determination of Disability

The following claims procedure applies specifically to claims made under the Plan for benefits based on a determination of disability. The claims procedure contained in the applicable Component Benefit Program document will supersede this procedure so long as the claims procedure in the applicable Component Benefit Program document complies with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA.

If a claim under the Plan for a benefit based on a determination of disability is denied in whole or in part, you or your beneficiary will receive written notification no later than 45 days after the claims fiduciary's receipt of the claim. The claims fiduciary may extend this period for up to 30 additional days provided it determines that the extension is necessary due to matters beyond its control, and you are notified of (1) the extension before the end of the initial 45-day period and (2) the date by which the claims fiduciary expects to render a decision. The 30-day extension can be extended by an additional 30 days if the claims fiduciary determines that, due to matters beyond its control, it cannot make the decision within the original extended period. In that event, you will be notified before the end of the initial 30-day extension of the circumstances requiring the extension and the date by which the claims fiduciary expects to render a decision.

The extension notice will explain the standards on which your entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information, if any, you must submit. If you must provide additional information, you will be provided with at least 45 days to provide the additional information. The period from which you are notified of the additional required information to the date you respond is not counted as part of the determination period.

A notice that your claim has been denied will be in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a description of any additional information needed to process the claim and an explanation of the claims review procedure; and a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you. The notice will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

You have 180 days to appeal an adverse benefit determination. You will be notified of the claims fiduciary's decision upon review within a reasonable period of time, but no later than 45 days after the claims fiduciary receives your appeal request. The 45-day period may be extended for an additional 45-day period if the claims fiduciary determines that special circumstances (such as the need to hold a hearing) require an extension of time. You will be provided with written notice prior to the expiration of the initial 45-day period. Such notice will state the special circumstances requiring the extension and the date by which the claims fiduciary expects to render a decision.

During the review of an adverse benefit determination, you will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim. You will be provided, upon request and free of charge, with reasonable access to and copies of, all documents, records, and other information relevant to your claim. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary who did not make the initial determination (and is not a subordinate of the individual who made the initial

determination) and will take into account all comments, documents, records or other information submitted by you relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination. If the determination was based on a medical judgment, including determinations regarding whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate fiduciary shall consult with one or more health care professionals who were not involved in the original benefit determination, have appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual consulted in connection with the initial determination, nor is a subordinate of the individual who made the initial determination. Upon request, the Plan Administrator will identify the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the benefit determination, without regard to whether such advice was relied upon in making the benefit determination.

Before issuing an adverse determination on review, the claims fiduciary will provide you, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated in connection with the claim, as well as a description of any new or additional rationale on which the denial is based. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

A notice that your appeal has been denied will be provided in writing and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a discussion of the decision, including an explanation of the basis for disagreeing with or not following the views of health care professionals treating you and vocational professionals who evaluated you; and a statement of your right to bring a civil action under section 502(a) of ERISA with a description of the limitations period provided by the Plan, including the date on which the limitations period will expire. The notice will also include a statement that you are entitled to receive, free of charge, access to all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

Claims Procedure for Group Health Plans

The following claims procedures apply specifically to claims made under any group health plan under this Plan (that is, the Medical, ACA Medical, Retiree Medical, Pharmacy, Dental, Vision, and Health FSA Component Benefit Programs). The claims procedure contained in the applicable Component Benefit Program document will supersede this procedure so long as the claims procedure in the applicable Component Benefit Program document complies with ERISA and the regulations thereunder and any applicable state law, to the extent not preempted by ERISA.

Benefit Determinations

Post-Service Claims

Post-Service Claims are those claims that are filed for payment of benefits after health care has been received. If your Post-Service Claim is denied, you will receive a written notice from the claims fiduciary within 30 days of receipt of the claim, so long as all needed information was provided with the claim. The claims fiduciary will notify you within the 30-day period if additional information is needed to process the claim and may request a one-time extension not longer than 15 days and pend your claim until all information is received.

Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame and the claim is denied, the claims fiduciary will notify you of a denial within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Pre-Service Claims

Pre-Service Claims are those claims that require certification or approval prior to receiving health care. If your claim was a Pre-Service Claim, and was submitted properly with all needed information, you will receive written notice of the claim decision from the claims fiduciary within 15 days of receipt of the claim. If you filed a Pre-Service Claim improperly, the claims fiduciary will notify you of the improper filing and how to correct it within 5 days.

After reviewing the revised Pre-Service Claim, the claims fiduciary will notify you of any additional information needed within 15 days and may request a one-time extension not longer than 15 days and pend your claim until all information is received. Once notified of the extension, you then have 45 days to provide this information. If all the needed information is received within the 45-day time frame, the claims fiduciary will notify you of the determination within 15 days after the information is received. If you don't provide the needed information within the 45-day period, your claim will be denied.

Urgent Care Claims

Urgent Care Claims are those claims that require notification or approval prior to receiving medical care, where a delay in treatment could seriously jeopardize your life or health or the ability to regain maximum function or, in the opinion of a doctor with knowledge of your health condition could cause severe pain. In these situations:

- You will receive notice of the benefit determination in writing or electronically as soon as possible, but not later than 72 hours after the claims fiduciary receives all necessary information, or such other timeframe as required under federal law, taking into account the seriousness of your condition.
- Notice of denial may be oral with a written or electronic confirmation to follow within 3 days.
- If you filed an Urgent Care Claim improperly, the claims fiduciary will notify you of the improper filing and how to correct it within 24 hours after the Urgent Care Claim was

received. If additional information is needed to process the claim, the claims fiduciary will notify you of the information needed within 24 hours after the claim was received. You then have 48 hours to provide the requested information.

You will be notified of a determination no later than 48 hours after the claims fiduciary's receipt of the requested information or the end of the 48-hour period within which you were to provide the additional information, if the information is not received within that time.

Concurrent Care Claims

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and your request to extend the treatment is an Urgent Care Claim as defined above, your request will be decided as soon as possible, and the claims fiduciary will notify you of the determination within 24 hours after receipt of the claim, provided your request is made at least 24 hours prior to the end of the approved treatment. If your request for extended treatment is not made at least 24 hours prior to the end of the approved treatment, the request will be treated as an Urgent Care Claim and decided according to the timeframes described above.

If an on-going course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service timeframes, whichever applies.

Notice of Claim Decision

Notice of an adverse claim determination will be provided in writing in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based; a description of any additional information needed to process the claim with an explanation of why the additional information is necessary; and an explanation of the claims review procedure. Upon request and free of charge, you will be provided a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

How to Appeal a Claim Decision

If you disagree with a claim determination you can contact the claims fiduciary in writing to formally request an appeal. Your appeal request must be submitted to the claims fiduciary within 180 days after you receive the claim denial.

During the review of an adverse benefit determination, you will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim. You will be provided, upon request and free of charge, with reasonable access to and copies of, all documents, records, and other information relevant to your claim. The review will not afford deference to the initial adverse benefit determination and will be conducted by an appropriate fiduciary who did not make the

initial determination (and is not a subordinate of the individual who made the initial determination) and will take into account all comments, documents, records or other information submitted by you relating to the claim regardless of whether the information was submitted or considered in the initial benefit determination. If the determination was based on a medical judgment, including determinations regarding whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate fiduciary shall consult with one or more health care professionals who were not involved in the original benefit determination, have appropriate training and experience in the field of medicine involved in the medical judgment, and who is neither the individual consulted in connection with the initial determination, nor is a subordinate of the individual who made the initial determination. The appropriate fiduciary may consult with, or seek the participation of, medical experts as part of the appeal resolution process. By filing an appeal, you consent to this referral and the sharing of pertinent health claim information. Upon request, the Plan Administrator will identify the medical experts whose advice was obtained on behalf of the Plan in connection with the benefit determination, without regard to whether such advice was relied upon in making the benefit determination.

Before issuing an adverse determination on review, the claims fiduciary will provide you, free of charge, with any new or additional rationale or evidence considered, relied upon, or generated in connection with the claim, as well as a description of any new or additional rationale on which the denial is based. This information will be provided as soon as possible and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided to give you a reasonable opportunity to respond prior to that date.

If your circumstance warrants an expedited appeals procedure, you should contact the claims fiduciary immediately. You will be asked to explain, in writing, why you believe the claim should have been processed differently and to provide any additional material or information necessary to support the claim.

Pre-Service and Post-Service Claim Appeals

You will be provided with written or electronic notification of the decision on your appeal as follows:

- For appeals of Pre-Service Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision within 15 days from receipt of a request for appeal.
- For appeals of Post-Service Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision within 30 days from receipt of a request for appeal.
- For appeals of Concurrent Care Claims, the appeal will be conducted, and you will be notified by the claims fiduciary of the decision before treatment ends or is reduced, or within 24 hours from receipt of a request for appeal if the claim is a request for extension involving urgent care.

Urgent Care Claim Appeals

Your appeal may require immediate action if a delay in treatment could significantly increase the risk to your health or the ability to regain maximum function or cause severe pain. In these urgent situations:

- The appeal does not need to be submitted in writing. You or your doctor should call the claims fiduciary as soon as possible.
- The claims fiduciary will provide you with a written or electronic determination as soon as possible, but not later than 72 hours following receipt of your request for review of the determination.

Notice of Adverse Decision on Appeal

Every notice of an adverse determination on appeal will be provided in a culturally and linguistically appropriate manner and will include the reasons for the denial, with reference to the specific provisions of the Plan on which the denial was based, and a description of the claims procedures for any additional level of appeal and the applicable time limits, external review rights, and a statement of your right to bring a civil action under Section 502(a) of ERISA after exhausting the Plan's claims procedures. The notice will also include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim, as well as a copy of any internal rule, guideline, protocol, or other similar criterion that was relied upon in making the adverse determination regarding the claim, and an explanation of the scientific or clinical judgment for a determination that is based on a medical necessity, experimental treatment or other similar exclusion or limit.

External Review

You may have the right to request an external review of a group health plan claim involving medical judgment, as determined by the external reviewer, or a coverage rescission. You must request the external review within four months of the date you receive an adverse benefit determination. If your request for an external review is determined eligible for such a review, an independent organization will review the claims fiduciary's decision and provide you with a written determination, as described in the Component Benefit Program document.

The external review decision is binding on you and the Plan, except to the extent other remedies are available under federal law. The external review process does not apply to an adverse benefit determination or final internal adverse benefit determination that is not related to medical judgment or coverage rescission.

D. *Exhaustion and Limitations Period.* Failure to appeal within the timeframe set forth in the applicable Component Benefit Program document will be deemed a failure to exhaust internal administrative appeal rights. The applicable Component Benefit Program's internal administrative appeal rights must be exhausted before a suit for benefits under this Plan may be initiated. Unless specifically provided otherwise in a Component Benefit Program document, a suit for benefits under this Plan must be brought within one (1) year after the date of a final decision on the claim in accordance with the applicable claims procedures.

X. General Information About the Plan

A. *Information to Be Furnished by Participants.* Participants shall provide the Plan Administrator and Insurance Companies and contract administrators to whom the Plan Administrator has delegated Plan administrative responsibilities with information and evidence, and shall sign documents, as may be requested by the Plan Administrator or applicable Insurance Company or contract administrator from time to time for the purpose of administration of the Plan. Participants and their covered family members shall submit to any examination reasonably ordered by the Plan Administrator, Insurance Company, or contract administrator when and so often as may be required to properly adjudicate a claim.

B. *No Contract of Employment.* The Plan is not intended to be, and may not be construed as constituting, a contract or other arrangement between any individual and any Employer to the effect that the individual will be employed for any specific period of time.

C. *No Vested Rights.* No Employee or former Employee, whether or not a Participant in, or eligible to participate in, the Plan, nor any eligible family member of such individual, shall at any time have any vested rights to benefits provided under the Plan or under any Component Benefit Program.

D. *No Guarantee of Tax Consequences*. Nothing in this document may be construed as tax or legal advice on the part of the Employers, the Plan Sponsor, or the Plan Administrator.

E. *Insurance Contract or Governing Document Controls.* Benefits under the Plan are provided pursuant to a governing plan document or insurance contract adopted by the applicable Employer. Except as expressly set forth in Article IX above, if the terms of this document conflict with the terms of such governing plan document or insurance contract, then the terms of the governing plan document or insurance contract will control, rather than this document, unless otherwise required by law.

F. *Non-Alienation and Non-Assignability of Rights.* No benefit payable under the provisions of the Plan or a Component Benefit Program, or any claim with respect thereto, shall be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge, and any attempt so to anticipate, alienate, sell, transfer, assign, pledge, encumber, or charge shall be void; nor shall such benefits be in any manner liable for or subject to the debts, contracts, liabilities, engagements, or torts of, or claims against, any Employee, former Employee or family member. All benefits and rights (including the right to request documents and bring a claim or lawsuit under ERISA) under the Plan and Component Benefit Programs are personal to the Participant or beneficiary and cannot be assigned or transferred to any other person or entity, and in no event will beneficiary standing be conveyed or assigned to any provider of services or supplies.

G. *Severability.* If any provision of the Plan (including the Component Benefit Programs) is held illegal or invalid for any reason, such illegality or invalidity shall not affect the remaining parts of the Plan. The provision shall be fully severable, and the Plan shall be construed and the provisions enforced as if the illegal or invalid provision had not been included in the Plan.

H. *Governing Law*. To the extent not preempted by ERISA or any other federal statutes or regulations, this Plan shall be governed by, and construed in accordance with, the laws of the Commonwealth of Massachusetts.

I. *Subrogation/Reimbursement.* If you or your covered family member file a claim for benefits that you or your covered family member have incurred which may be the responsibility of a third party, you or your covered family member may be required to reimburse the Plan from any recovery received. For example, if you are injured in an automobile accident which is not your fault, you may have to repay the Plan for the benefits you collect or that are paid from the third party responsible for the accident, or from their insurance company, or anyone else from which you receive payment for the accident. You or your covered family member must: (1) notify the Plan of any claim that you or your covered family member may have against any third party as soon as you or your covered family member become aware of the claim, (2) sign any subrogation/reimbursement agreement requested by the Plan, and (3) cooperate with the Plan in all attempts to collect from the third party. This means that the Plan has the right to act on behalf of you or you covered family member in pursuing payment from the third party.

XI. ERISA Statement of Rights

A. *ERISA Coverage.* This Plan and the Component Benefit Programs are governed by ERISA to the extent they provide certain medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, or death. This Plan document and summary plan description does not describe the Component Benefit Programs providing ERISA-covered benefits in any detail. Participant rights and information regarding ERISA-covered benefit programs are contained in the separate Component Benefit Program documents and summary plan descriptions.

B. *Your Rights.* As a participant in a covered employee benefit plan, you are entitled to certain rights and protections under ERISA. ERISA provides that all plan participants shall be entitled to:

Receive Information about your Plan and Benefits

- Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites, all documents governing the plan, including insurance contracts, and a copy of the latest annual report (Form 5500 Series), if any, 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, upon written request to the plan administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The plan administrator may make a reasonable charge for the copies.

- Receive a summary of the plan's annual financial report, if any. The plan administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

- Continue group health plan coverage in some cases for yourself, spouse or dependents if there is a loss of coverage under the plan as a result of a "qualifying event" under COBRA. You or your dependents may have to pay for such coverage. Review the summary plan description and documents governing the group health plan on the rules governing your COBRA continuation coverage rights.

Prudent Action by Plan Fiduciaries

- In addition to creating rights for plan participants, ERISA imposes duties upon the people who are responsible for the operation of a covered employee benefit plan. The people who operate the 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 fire you or otherwise discriminate against you in any way to prevent you from obtaining a plan benefit or exercising your rights under ERISA.

Enforce Your Rights

- If your claim for a benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

- Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report (if any) from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the plan administrator.

- If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If you disagree with the plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay 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 is frivolous. However, no legal action may be commenced or maintained against the plan until after you exhaust the plan's claims procedures described covered employee benefit plan's summary plan description.

Assistance with Your Questions

- If you have any questions about your covered employee benefit plan, you should contact the plan administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the

plan administrator, you should you should visit the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) website at www.dol.gov/ebsa or call its toll-free number at 1-866-444-3272.

Beth Israel Lahey Health, Inc. has caused this Beth Israel Lahey Health, Inc. Employee Benefits Plan to be executed by its duly authorized officer this 29th day of May, 2025.

Beth Israel Lahey Health, Inc.

By _____

Its EVP, Chief Human Resources Officer

EMPLOYER SCHEDULES

Schedule for:

Beth Israel Deaconess Medical Center, Inc.
Beth Israel Deaconess Hospital – Needham, Inc.
Medical Care of Boston Management Corp., Inc., d/b/a Beth Israel Deaconess HealthCare a/k/a Affiliated Physicians Group
Anna Jaques Hospital, Inc. and Seacoast Affiliated Group Practice, Inc.
Beth Israel Deaconess Hospital – Milton, Inc. and Community Physician Associates
Beth Israel Deaconess Hospital – Plymouth, Inc. (Management/UFSPSO)
New England Baptist Hospital, New England Baptist Medical Associates
Joslin Diabetes Center, Inc.*
Northeast Hospital Corporation
Northeast Professional Registry of Nurses, Inc.
Northeast Senior Health Corporation
Northeast Behavioral Health Corporation
Lahey Clinic Hospital, Inc.
Lahey Clinic, Inc.
Beth Israel Lahey Health Performance Network, LLC.
Beth Israel Lahey Health Primary Care, Inc.
Beth Israel Lahey Health Specialty Care, Inc.
Winchester Hospital

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision		EyeMed
Flexible Benefit Plan – Pre-tax premium payments, Health FSA, Dependent Care FSA		Sentinel
Short Term Disability		Unum
Long Term Disability		Unum
Life Insurance		Voya
Voluntary Accidental Death & Dismemberment		Voya
Legal Insurance		ARAG
Critical Illness Insurance		Voya

Hospital Indemnity		Voya
Accident Insurance		Voya
Employee Assistance Program	Offered to all employees (and their adult household members)	KGA
ACA Medical Plan	Eligibility: Employees that are not eligible for medical benefits under the eligibility rules above Effective Date: Date of hire (or rehire) or change in status	Sentinel
Retiree Medical (post 65)	Closed Grandfathered Groups	BIDMC, Inc.; BIDH – Needham; Medical Care of Boston Management Corp., Inc., d/b/a Beth Israel Deaconess HealthCare a/k/a Affiliated Physicians Group; Winchester Hospital: BCBSMA Northeast Hospital Corporation: Transamerica & ESI

* Note: The COBRA administrator for the covered Joslin Diabetes Center, Inc. health plans is HealthEquity. The COBRA administrator for all other covered health plans is Sentinel.

Schedule for Beth Israel Deaconess Hospital – Plymouth, Inc.

Plymouth MNA

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 16 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	EyeMed
Flexible Benefit Plan – Pre-tax premium payments, Health FSA, Dependent Care FSA		Sentinel
Short Term Disability		Unum
Long Term Disability		Unum
Life Insurance		Voya
Basic Accidental Death & Dismemberment		Voya
Critical Illness		Voya
Group Accident		Voya
Hospital Indemnity		Voya
Legal Insurance		ARAG
ACA Medical Plan	Eligibility: Employees that are not eligible for medical benefits under the eligibility rules above Effective Date: Date of hire (or rehire) or change in status	Sentinel
Employee Assistance Program	All employees, household members, and dependents	KGA

Note: COBRA administrator for the covered health plans is Sentinel.

Schedule for Beth Israel Deaconess Hospital – Plymouth, Inc.

Plymouth SEIU

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 15 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	EyeMed
Flexible Benefit Plan – Pre-tax premium payments, Health FSA, Dependent Care FSA		Sentinel
Short Term Disability		Unum
Long Term Disability		Unum
Life Insurance		Voya
Basic Accidental Death & Dismemberment		Voya
Critical Illness		Voya
Accident Insurance		Voya
Hospital Indemnity		Voya
Legal Insurance		ARAG
ACA Medical Plan	Eligibility: Employees that are not eligible for medical benefits under the eligibility rules above Effective Date: Date of hire (or rehire) or change in status	Sentinel
Employee Assistance Program	All employees, household members, and dependents	KGA

Note: COBRA administrator for the covered health plans is Sentinel.

Schedule for:

Beth Israel Lahey Health, Inc.

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision		EyeMed
Flexible Benefit Plan – Pre-tax premium payments, Health FSA, Dependent Care FSA		Sentinel
Short Term Disability		Unum
Long Term Disability		Unum
Life Insurance		Voya
Critical Illness Insurance		Voya
Hospital Indemnity		Voya
Accident Insurance		Voya
Voluntary Accidental Death & Dismemberment		Voya
Legal Insurance		ARAG
Employee Assistance Program	Offered to all employees (and their adult household members) Effective Date: Date of hire (or rehire) or change in status	KGA
ACA Medical Plan	Eligibility: Employees that are not eligible for medical benefits under the eligibility rules above Effective Date: Date of hire (or rehire) or change in status	Sentinel

Note: COBRA administrator for the covered health plans is Sentinel.

Schedule for Mount Auburn Hospital, Mount Auburn Professional Services, Inc.

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision		EyeMed
Flexible Benefit Plan – Pre-tax premium payments, Health FSA, Dependent Care FSA		Sentinel
Life Insurance		Voya
Voluntary Accidental Death & Dismemberment		Voya
Legal Insurance		ARAG
Critical Illness Insurance		Voya
Hospital Indemnity		Voya
Accident Insurance		Voya
Short Term Disability		Unum
Long Term Disability		Unum
Employee Assistance Program	Eligibility: All Employees, including temporary and per diem employees Effective Date: Date of hire (or rehire) or change in status	KGA
ACA Medical Plan	Eligibility: Employees that are not eligible for medical benefits under the eligibility rules above Effective Date: Date of hire (or rehire) or change in status	Sentinel
Retiree Medical (post 65)	Closed to new retirees. Employees who met all of the following criteria on or before September 30, 1993, are eligible: age 55-plus; regularly scheduled for at least 20 hours/week when employed; and employed at least 10 years	Tufts & BCBSMA

	Coverage begins at age 65 or upon retirement, whichever is later	

Note: COBRA administrator for the covered health plans is Sentinel.

Schedule for

Exeter Hospital, Inc.
Core Physicians, LLC

Benefit Program	**Eligibility & Participation**	**Claims Administrator**
Medical	Eligibility: Employees regularly scheduled for at least 20 hours/week Effective Date: Date of hire (or rehire) or change in status	Harvard Pilgrim Health Care
Pharmacy		InScript
Dental		Delta Dental of Massachusetts
Vision		EyeMed
Life Insurance		Voya
Short Term Disability		Unum
Long Term Disability		Unum
Employee Assistance Program	Eligibility: All Employees, including temporary and per diem employees Effective Date: First of the month following date of hire (or rehire)	KGA

Note: COBRA administrator for the covered health plans is Voya.

Exhibit A
Plan Sponsor Access to Protected Health Information

Only the employees or classes of employees of the Employer or an Affiliate with the titles listed on this Exhibit, or individuals who serve in a similar function as individuals with the titles listed on this Exhibit, shall be given access to protected health information. Collectively, the individuals listed on this Exhibit are the "Permitted Employees."

- Director of Pharmacy Data and Analytics
- Medication Authorization and Access Manager
- Medication Authorization and Access Supervisor
- Medication Authorization Coordinators
- Specialty Pharmacy Liaison
- Data Analyst
- Manager Data Analytics
- Program Manager
- Salesforce Developer
- Direct Pharmacist
- Vice President, Clinical Pharmacy
- Vice President, Strategy
- Strategy Manager
- Patient Navigator
- Population Health Specialist
- Manager Ambulatory Clinical Pharmacy
- Clinical Pharmacist, Ambulatory
- Clinical Pharmacy Specialist, Ambulatory
- Director Ambulatory Clinical Pharmacy

The Employer shall promptly amend this Exhibit, as necessary or appropriate and consistent with the requirements of the Privacy Rule, to ensure that it is accurate and up-to-date.

This Exhibit A, as set forth in this amended and restated Plan document, shall be effective January 1, 2025.